Tuscarawas Valley Urology, Ltd. PATIENT HEALTH HISTORY

NAME _____ OCCUPATION _____

Please take the time to accurately complete this form.
It is very important that we have an accurate medical history to provide you with the best urologic care.

PAST/CURRENT ILLNESSES

__Asthma
__Drug/Alcohol problems
__TB (Tuberculosis)
__Kidney Stones
__Heart Problems
__High Cholesterol
__Rheumatic Fever
__Diabetes
__Stroke
__Cancer—TYPE_____
__Anemia
__Prostate Problems
__Ulcers
__Mental Illness
__Seizures
__Depression
__Back Problems
__Thyroid disease
__Gall stones
__Hepatitis—A B C
__Liver problems
__Bleeding problems
__Skin problems
__Hearing loss
__Sexually transmitted diseases
__HIV or AIDS
__Headaches
__Vision problems
__High Blood Pressure
__Other_____
_____
_____

ALLERGIES

Please check any allergies that you have had and write down the reactions.

__Penicillin _____
__Sulfa _____
__Aspirin _____
__Codeine _____
__Bee Stings _____
__Foods _____
__Other_____
_____

ALCOHOL USE_____ TYPE_____
Amount_____ How Often_____

TOBACCO USE—YES__ NO__ QUIT_____
TYPE_____ Amount per day_____

SURGERIES

__Appendix __Tonsils
__Gall bladder __Breast
__Other_____
_____

HOSPITALIZATIONS

Please list dates and reasons for all hospitalizations.

DATE REASON

_____
_____
_____
_____

FAMILY HISTORY

Please list any diseases, and family member who has/had it, that run in the family.

_____
_____
_____

MEDICATIONS

Please list any medications you take, both prescription and over-the-counter. Give dosage and how often taken:

_____
_____
_____
_____
_____
_____
_____

I hereby certify that the above information is accurate and complete: X_____
(signature)