



Alpine Urology
Medical History Sheet

Patient Name: _____ **Date:** _____

Referring Physician: _____ **General Physician:** _____

Reason for Today's Visit: _____

Recent X-ray's or labwork:

What: _____ **Where:** _____ **Date:** _____

What: _____ **Where:** _____ **Date:** _____

Medical History: (please mark all you have ever been treated for or are currently being treated)

Alcoholism: _____ Drug Abuse: _____

Urinary Tract Infection: _____ Sexually Transmitted Disease: _____

Glaucoma: _____ Stroke/TIA: _____

High Blood Pressure: _____ Heart Problems: _____

Asthma/COPD: _____ Tuberculosis: _____

Hepatitis: _____ Acid reflux/GERD: _____

Diabetes: _____ Thyroid disease: _____

Arthritis/Gout: _____ Rheumatic Fever: _____

Artificial Heart Valve: _____ Artificial Joints: _____

Kidney Problems: _____ Cancer: _____

Other: _____

Surgical History: (please list all surgeries you have had)

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

Vasectomy: Yes _____ No _____ **Date:** _____ **Hysterectomy:** Yes _____ No _____ **Date:** _____

Social History:

Alcohol use: No _____ Yes _____ How much daily? _____ How many years? _____

Tobacco use: No _____ Quit: when? _____ Yes: # packs/daily _____ How many years? _____

Daily Fluid Intake: Caffeine: _____ Tea: _____ Juice: _____

Water: _____ Soda/Pop: _____ Milk: _____

Family History: (please list which relative has this, not including yourself)

Cancer _____ Diabetes _____

Kidney Stones _____ Hypertension _____

Heart Problems _____ Gout _____

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

Nurse/MA Signature: _____ **Date:** _____