



PIONEER VALLEY

UROLOGY, P.C.

Today's Date: _____

Name: _____ Date of Birth: _____

Sex: Male / Female

Referring MD: _____ Primary Care Physician: _____

Pharmacy: Name _____
Location _____
Phone (if known) _____

Chief Complaint (reason you are here):

Medical History/Problems:

Surgeries (procedure and date):

Medications (Name, dose and frequency):

FEMALES:

Pregnancies _____ Live births _____ Last Menstrual Period: _____

PLEASE COMPLETE REVERSE SIDE



Name: _____

Account No.: _____

ALLERGIES (explain reactions)

Social History

Work History: _____

Alcohol Use: No Yes; If So: _____ Drinks per day

Marital Status: _____

Tobacco Use: No Yes; If So: _____ Packs per day

Family History: (Include Father, Mother, Siblings and Children)

Heart Disease: Explain _____

High Blood Pressure: Explain _____

Diabetes: Explain _____

Cancer: Explain _____

Review of Systems

Do you currently experience or have difficulty with any of the following problems? If yes, please explain on line(s) below.

General/Overall

Fever/Chills..... no yes
Headache..... no yes
Recent weight change..... no yes

Sore Throat..... no yes
Sinus pain..... no yes
Hearing loss..... no yes

Neurological System

Tremors..... no yes
Dizziness..... no yes
Numbness or tingling sensation..... no yes

Skin

Rash..... no yes
Lesion..... no yes

Stomach

Abdominal Pain..... no yes
Nausea or Vomiting..... no yes
Bleeding..... no yes
Heartburn..... no yes

Muscle/Skeletal System

Joint pain..... no yes
Neck or Back pain..... no yes
Muscle aches..... no yes

Heart

Chest pain or discomfort..... no yes
Varicose veins..... no yes
Murmur..... no yes
High blood pressure..... no yes

Lungs

Wheezing..... no yes
Cough..... no yes
Shortness of breath..... no yes

Eyes

Blurred vision..... no yes
Double Vision..... no yes
Eye pain..... no yes

Blood/Lymph System

Swollen glands..... no yes
Blood clotting problems..... no yes
Bruise easily..... no yes

Allergic

Hay fever..... no yes
Drug Allergies..... no yes

Psychologic

Trouble sleeping..... no yes
Anxiety..... no yes
Depression..... no yes

Ears/Nose/Throat/ Mouth

Ear infection..... no yes

Other: _____