

ATHENA UROLOGY ASSOCIATES

Name: _____ Date of birth: ___/___/___ Today's date: ___/___/___

History of Present Illness

What is the reason for your visit? _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

Where were you when this problem started? _____

What other things happen with this problem? _____

Patient Past Medical History

Have you ever had the following:

Acute Infections..... No Yes
Arthritis..... No Yes
Cancer – Type _____ No Yes
Convulsion..... No Yes
Coronary Artery Disease..... No Yes
Diabetes..... No Yes
Hepatitis..... No Yes

Hypertension..... No Yes
Kidney Stones..... No Yes
Latex Allergy..... No Yes
Pace Maker..... No Yes
Thyroid Disease..... No Yes
Venereal Disease..... No Yes

LIST ALL PRIOR SURGERIES/RECENT HOSPITALIZATIONS

Surgery: _____ Hospital: _____ Date: _____

Surgery: _____ Hospital: _____ Date: _____

Surgery: _____ Hospital: _____ Date: _____

Surgery: _____ Hospital: _____ Date: _____

Surgery: _____ Hospital: _____ Date: _____

Patient Social History

Marital Status: Divorced Married Separated Single Widowed

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously but quit Current packs per day_____

Use of drugs: Never Type/frequency_____

Family Medical History:

	Age	Disease Type and Diagnosis date	Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children _____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____