PIONEER VALLEY
UROLOGY, P.C.

*Today's Date:*_____ *Account No.:*_____

*Name:*_____ *Date of Birth:*_____

Sex: *Male / Female* *Height:*_____ *Weight:*_____

*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- include supplements and over the counter medications (Name, dose and frequency):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FEMALES:

*Pregnancies*_____ *Live births*_____ *Last Menstrual Period:*_____

PLEASE COMPLETE (1 of 2 pages)

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)

☐ *Kidney Stones: Explain*_____ ☐ *Heart Disease: Explain*_____

☐ *Kidney Cancer: Explain*_____ ☐ *High Blood Pressure: Explain*_____

☐ *Prostate Cancer: Explain*_____ ☐ *Diabetes: Explain*_____

☐ *Other 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

Neurological System

Tremors..... no yes

Dizziness..... no yes

Numbness or tingling sensation..... no yes

Stomach

Abdominal Pain..... no yes

Nausea or Vomiting..... no yes

Bleeding..... no yes

Heartburn..... no yes

Heart

Chest pain or discomfort..... no yes

Varicose veins..... no yes

Murmur..... no yes

High blood pressure..... no yes

Eyes

Blurred vision..... no yes

Double Vision..... no yes

Eye pain..... no yes

Allergic

Hay fever..... no yes

Drug Allergies..... no yes

Ears/Nose/Throat/ Mouth

Ear infection..... no yes

Sore Throat..... no yes

Sinus pain..... no yes

Hearing loss..... no yes

Skin

Rash..... no yes

Lesion..... no yes

Muscle/Skeletal System

Joint pain..... no yes

Neck or Back pain..... no yes

Muscle aches..... no yes

Lungs

Wheezing..... no yes

Cough..... no yes

Shortness of breath..... no yes

Blood/Lymph System

Swollen glands..... no yes

Blood clotting problems..... no yes

Bruise easily..... no yes

Psycho logic

Trouble sleeping..... no yes

Anxiety..... no yes

Depression..... no yes

Other:_____

PLEASE COMPLETE (2 of 2 pages)