EL CAMINO UROLOGY MEDICAL GROUP

2490 Hospital Drive, Ste 210, Mountain View, CA 94040 Health History

Circle Y or N to all illnesses/conditions that apply to you now or in the past					
Illness	**Currently**		**Previously**		**Explain or describe**
Cancer(type_____)	**Y**	**N**	**Y**	**N**	
Diabetes	**Y**	**N**	**Y**	**N**	
Heart Disease	**Y**	**N**	**Y**	**N**	
Hepatitis	**Y**	**N**	**Y**	**N**	
High Blood Pressure	**Y**	**N**	**Y**	**N**	
High Cholesterol	**Y**	**N**	**Y**	**N**	
Kidney Disease/Stones	**Y**	**N**	**Y**	**N**	
Thyroid Disease	**Y**	**N**	**Y**	**N**	
Vascular Disease/Blood clots	**Y**	**N**	**Y**	**N**	
Other medical illnesses:					

What is your height:_____ and approximate weight:_____

Do you take antibiotics before going to the dentist? Yes / No. If Yes, why_____

SURGICAL HISTORY		
Operation	**Month/Year**	**Where was the surgery done**

FAMILY HISTORY		
Has anyone in your family had problems with:		**If Yes, parent, sibling, grandparent, or other**
Infertility	**Y N**	
Heart Disease	**Y N**	
Kidney Stones	**Y N**	
Prostate Cancer	**Y N**	
Urologic/gynecologic cancers	**Y N**	

SOCIAL HISTORY

Do you smoke? Yes/ No ; Packs/day_____; Years smoked _____; Quit in _____

Do you drink? Yes/ No. If yes, Number of drinks per day_____per week_____

Do you exercise regularly? Yes or No. If yes, type & frequency of activity_____

Occupation_____

Patient Name : _____

Today's Date: _____ MD Initials_____Date_____

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Please list your current medications below			
Medications & Dosage	**Frequency**	**Medications & Dosage**	**Frequency**

Allergies to any medications: YES / NO

Name & Reaction_____

Have you ever had an allergic reaction to iodine/ shellfish / Imaging contrast? YES/ NO

If yes describe your reaction_____

Are you allergic to LATEX? YES / NO (If yes, describe your reaction) _____

Have you been diagnosed in the last week with an Infectious Cough / Shingles / Chicken Pox / Meningitis / TB : YES / NO (We are not providers for this and are trying to protect our patients and staff.)

Do you now or have you had problems related to the following systems? Circle Y or N

General Health			
Fever	**Y / N**	Chills	**Y / N**
Eyes			
Blindness	**Y / N**	Eye Pain	**Y / N**
Ear/Nose/Throat/Mouth			
Frequent Nosebleeds	**Y / N**	Deafness	**Y / N**
Cardiovascular			
Palpitations	**Y / N**	Chest Pain	**Y / N**
Respiratoty			
Shortness of Breath	**Y / N**	Frequent Cough	**Y / N**
Gastrointestinal			
Nausea/Vomiting	**Y / N**	Constipation	**Y / N**
Genitourinary			
Blood in Urine	**Y / N**	Painful Urination	**Y / N**
Integumentary			
Rashes	**Y / N**	Itching	**Y / N**
Neurologic			
Numbness	**Y / N**	Tingling	**Y / N**
Musculoskeletal			
Back Pain	**Y / N**	Neck Pain	**Y / N**
Hematologic/Lymphatic			
Blood clotting problem	**Y / N**	Swollen glands	**Y / N**

Patient Name : _____

Today's Date: _____ MD Initials_____Date_____