Today's Date: _____ Patient's Name: _____ DOB: _____

HISTORY OF THE PRESENT ILLNESS: - Please answer all questions
Where is your problem: _____
How long have you had this problem: _____
What makes this better or worse: _____
How severe is your problem: _____
When does this bother you more: _____
Describe any discharge or odor: _____

PAST MEDICAL HISTORY: - Have you had or been treated for the following:

	Yes	No
High blood pressure	____	____
Heart disease	____	____
Diabetes mellitus	____	____
Seizures	____	____
Venereal disease	____	____
Stomach ulcer	____	____
Shortness of breath	____	____

PAST SURGICAL HISTORY: - Please list most current first and dates
1. _____
2. _____
3. _____
4. _____

LIST ANY MEDICATIONS YOU TAKE:
1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10_____

ALLERGIES: - Are you allergic to: Please circle or list them
Penicillin Sulfa Codeine Morphine _____

FAMILY HISTORY:
Any family history of bladder, kidney or prostate cancer:
Mother: _____
Father: _____

SOCIAL HISTORY:
Current weight: _____
Tobacco use: Cigarettes: Yes / No Packs/day:_____ Cigars: Yes / No Pipe: Yes / No
Snuff: Yes / No Chewing Tobacco: Yes / No
How much alcoholic beverages per day?_____

Date:_____ Signature: _____

Date: _____ Physician Signature: _____