Gulfshore UROLOGY

A Division of 21st Century Oncology, LLC

PATIENT MEDICAL INFORMATION SHEET

NAME:______________________________ DOB:____________ DATE:__________

MEDICATION ALLERGIES: (Circle/Fill all that apply)

NONE	Codeine	Penicillin	Sulfa
Cipro/Levaquin	Nitrofurantoin	Hydrocodone	Morphine
Statins	Latex	IV Dye/Iodine	

Other: ____

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:_______________ Quit:__________

Alcohol: Currently Past Never Drinks/day:_______________ Quit:__________

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications	OTC and vitamins
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD	HIV	Peptic Ulcer
Alcoholism	Dementia	Hepatitis	Psoriasis
Allergies	Depression	Irritable Bowel	Pulmonary
Anemia	Diabetes: 1or 2	Kidney Stones	Prostate Cancer
Arthritis	Diverticulitis	Kidney Disease	Rheumatoid
Arrhythmia	DVT (Blood Clot)	Kidney Cancer	Sciatica
Anxiety	Eczema	Lung Cancer	Seizure Disorder
Apnea	Emphysema	Lupus	Sleep Disorder
Asthma	Gallstones	Liver Disease	Stroke
Bipolar Disorder	GERD	Macular Degeneration	Thyroid Disorder
Bladder Cancer	Glaucoma	Migraines	Ulcerative Colitis
Bleeding Disorder	High Cholesterol	Nosebleeds	Urinary Incontinence

Patient Name:____

Surgical History: Please list all prior surgeries and approximate dates performed.

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FAMILY HISTORY:

FATHER: Living: Age________ Deceased: Age________

COPD/Emphysema Colon Cancer Stroke Heart Disease
Breast Cancer Bladder Cancer Kidney Disease Prostate Cancer
High Blood Pressure Diabetes 1 or 2
Other:____

MOTHER: Living: Age_________ Deceased: Age:__________
COPD/Emphysema Colon Cancer Stroke Heart Disease
Breast Cancer Bladder Cancer Kidney Disease High Blood Pressure
Diabetes 1or2
Other:____

Siblings:____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Pulmonologist, etc.)

Primary Care Physician:____

Cardiologist:____

Pulmonologist:____

Other:____

Preferred Pharmacy:______________________________Phone Number:_______________

Patient signature: ____Date:____________