



Urology Consultants, Ltd.

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Welcome to our practice. To simplify the process on your first visit please complete the enclosed patient information forms prior to your arrival. Additionally, you will need to present a current insurance card upon your arrival. If your insurance requires a referral from your primary care physician it is your responsibility either to bring it with you, or to insure that it has been transmitted to us. We strongly encourage you to contact your insurance carrier to determine whether or not you need a referral for your visit to the urologist.

In order to help maintain health care costs we require all co-pays at the time of check-in. If you wish to acquaint yourself with our practice you may visit our website at www.ucl-stl.com.

We look forward to seeing you.

Sincerely,

The physicians and staff at Urology Consultants, Ltd.

Patient's Name: _____ Patient's Height: _____ Patient's Weight: _____

Reason For Visit/Chief Complaint: _____ Date Symptoms Began: _____

PAST SURGICAL HISTORY

Surgeries/Hospitalizations:	
1.	5.
2.	6.
3.	7.
4.	8.

Check box if list continues

Have You Ever Had A Problem With Anesthesia? No Yes:

Explain: _____

Medication/Vitamins/Supplements	Dose	Medication/Vitamins/Supplements	Dose	Medication/Vitamins/Supplements	Dose
1.		5.		9.	
2.		6.		10.	
3.		7.		11.	
4.		8.		12.	

Check box if list continues

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL/MEDICAL PROCEDURES? _____ YES _____ NO

ALLERGIES/TYPE OF REACTION

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FAMILY HISTORY (Check all that apply.)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Anesthesia Problems	<input type="checkbox"/> Other _____

SOCIAL HISTORY

Tobacco Use: No Yes, Packs per day? _____ for _____ Years Stopped - When? _____

Daily Alcohol Use: No Yes, Amount? _____ Coffee: No Yes, Amount? _____

PAST MEDICAL HISTORY

	No	Yes		No	Yes		No	Yes
Stroke or TIA			Depression			Emphysema		
Heart Attack			Panic Attack			Asthma		
Heart Murmur			Epilepsy			Tuberculosis		
High Blood Pressure			Reflux - (GERD)			Diabetes		
High Cholesterol			Ulcers			Cancer		
DVT or Blood Clots			Hypothyroid			Enlarged Prostate		
Bleeding Tendencies			Kidney Disease			HIV		
Anemia			Kidney Stones			Arthritis DJD		
Hepatitis - What Type			COPD					

REVIEW OF SYSTEMS

Symptom	No	Yes		No	Yes
Weight Loss			Heartburn		
Fever and/or Chills			Difficult Urination		
Double Vision			Pain or Burning on Urination		
Loss of Vision			Blood in Urine		
Loss of Hearing			Frequent Urge to Empty Bladder		
Severe Nose Bleeds			Loss of Urine when Laughing, Coughing, etc.		
Hoarseness			Weakness		
Frequent sore Throats			Frequent Itching		
Shortness of Breath with Exertion			Rashes		
Swelling of Feet or Ankles			Skin Cancer		
Sudden Changes in Rate of Heart Beat			Numbness/Tingling		
Pain or Pressure in Chest with Exertion			Seizures		
Awakened at Night Short of Breath			Memory Loss		
Asthma			Balance Problems		
Chronic Cough			Do you worry a lot?		
Coughing up Blood			Are you a nervous person?		
Frequent Chest or Bronchial Infections			Are you Frequently Unhappy or Depressed?		
Nausea or Vomiting			Excessively Thirsty, Hot, Cold, Sleepy		
Vomiting of Blood			Seasonal Allergies		
Any Change in Bowel Habits					

Doctor's Signature _____