Memorial Hermann Medical Group
New Patient Medical History - Urology

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Email: _____

Reason for your visit: _____

How did you hear about us? _____

PCP Name: _____ PCP Address: _____

PCP Fax: _____

Do you have a Cardiologist? ☐ No ☐ Yes Name of Cardiologist: _____

FAMILY MEDICAL HISTORY

Please mark any conditions in your family.

CONDITION	FATHER	MOTHER	BROTHER	SISTER	OTHER
Blood/clotting disorder					
Cancer (what kind?)					
Diabetes					
Depression					
Heart attack (what age?)					
High blood pressure					
High Cholesterol					
Kidney disease					
Stroke					
Other					

PAST MEDICAL HISTORY

Please mark any conditions that apply to you.

☐ Anxiety
☐ Asthma
☐ Blood/clotting disorder
☐ Cancer: _____
☐ Depression
☐ Diabetes
☐ Emphysema (COPD)
☐ Heart attack (what age?) _____
☐ Heart disease (blocked arteries)
☐ Heart failure
☐ High blood pressure
☐ High cholesterol
☐ Kidney disease
☐ Kidney stones
☐ Osteoporosis
☐ Stroke
☐ Thyroid disease
☐ Other: _____

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SURGICAL HISTORY

Please list any surgeries you've had.	Date

HEALTH MAINTENANCE

Have you had these tests?	If Yes, please list date (month/day/year) and results.	No
Bone Density Screening		
Colorectal Cancer Screening		
o Colonoscopy		
o Fecal immunochemical test (FIT-DNA) (Ex: Cologuard)		
o Fecal occult blood test (FOBT) (Ex: Hemoccult Sensa)		
o Other - List name of test		
Diabetic Eye Exam		
Mammogram		
Pap Smear		
PSA		

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SOCIAL HISTORY

Tobacco Use: ☐ Current every day ☐ Current some days ☐ Former ☐ Never

Type (if applicable): _____

Tobacco Exposure: ☐ None ☐ At Work ☐ At Home

If you're a current or past smoker, have you smoked in the last year? ☐ Yes ☐ No

Alcohol Use: ☐ Current ☐ Past ☐ Never

Type (if applicable): ☐ Beer ☐ Wine ☐ Liquor

How often: 1-2x/year 1-2x/month 1-2x/week 3-5x/week daily 2x/day

Substance Use: ☐ Current ☐ Past ☐ Never

Type (if applicable): _____

Have you ever been pregnant? ☐ N/A ☐ No ☐ Yes

If yes, list pregnancies here:

YEAR	DELIVERY: VAGINAL, CESAREAN, PREGNANCY LOSS, ETC

Did you have any complications during your pregnancies? ☐ N/A ☐ No ☐ Yes

If yes, please describe: _____

_____

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MEDICATIONS

☐ **I am not taking any medications.**

☐ **I brought a list of my medications from home. [You do not need to write down your medications if you brought a complete list].**

List all medications prior to assessment. Include over-the-counter, alternative medications, herbals and prescriptions.

MEDICATION NAME	STRENGTH	NUMBER OF PILLS AT ONE TIME?	HOW MANY TIMES A DAY?	PRESCRIBER	TAKING AS PRESCRIBED?
Example: *Tylenol*	*100mg*	*1*	*2*	*Dr. Smith*	☒ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Local Pharmacy: _____ Phone Number: _____

Mail Order Pharmacy: _____ Phone Number: _____

ALLERGIES

☐ **No Known Allergies**

MEDICATION / FOOD / ENVIRONMENTAL	REACTION	SEVERITY
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

I have completed the above to the best of my knowledge.

Patient / Guardian Signature **Print Name** **Relationship to patient** **Date**