UROLOGY ASSOCIATES LTD

6525 FRANCE AVE S, STE 200 EDINA, MN 55435 . PHONE: 952-927-6501. FAX: 952-922-1623

Past Medical History (Circle any illnesses and tell us when they occured.)

Check this box if not known or none apply

Condition	Date	Condition	Date
Anemia		Heart Attack (MI)	
Arthritis		Hepatitis	
Asthma		Hypertension (HBP)	
Atrial Fibrillation		Hypothyroidism	
Breast Cancer		Irritable Bowel Synd.	
CAD		Migraines	
COPD		Hypercholesterolemia	
Chest Pains (Angina)		Osteoporosis	
Crohns		Paraplegia	
Depression		Quadriplegia	
Diabetes		Seizures	
Diverticulosis		Spine Problems/Pain	
Gout		Stroke / CVA	
Other Information			

Past Surgery (Circle past surgeries and tell us when they occured.)

Check this box if not known or none apply

Amputation		Kidney/Ureter Stone (Basketing)	
Angioplasty		Kidney/Ureter Stone (ESWL)	
Appendectomy		Mesh Hernia Repair	
AV Fistula		Ortho Surgery	
Back Surgery		Peripheral Bypass Surgery	
Cardiac Bypass		Colon Resection	
Gall Bladder removal		Gastric Bypass	
Hernia Repair		Prostate Surgery (TURP)	
Small Bowel Resection		Radiation Therapy (CA Prostate)	
Radical Prostatectomy		Radiation Therapy (CA Prostate)	
Prostate Surgery (TUNA)		Indigo Laser	
Other Information			

Past Urologic History (Circle any illnesses and tell us when they occured.)

Check this box if not known or none apply

Bladder Cancer		Prostate Cancer	
Enlarged Prostate (BPH)		Prostatitis	
Impotence		Renal Insufficiency / Failure	
Kidney Cancer		Urinary Incontinence	
Kidney Cyst		Urinary Tract Infections (UTI)	
Kidney Stones		Vasectomy	
Other Information			

Family History Check box(es) for any illnesses in your immediate family.					
Check this box if not known or none apply ☐					
Condition	Father	Mother	Brother	Sister	Family
Asthma	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Enlarged Prostate	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐
Other Information					

Social History	
Do you smoke? ○ Yes ○ No	How much?
Past smoking? ○ Yes ○ No	
Do you drink? ○ Yes ○ No	How much?
Past drinking? ○ Yes ○ No	Socially / Occasionally / Heavy / Recovering Alcoholic
Living at: ________ (Home/Nursing home etc)	Illicit drug use? ○ Yes ○ No
Other Information	

Past Medications (Please list all medications and dosage.)				
Medicines	Strength	Dosage	Duration	Notes