GULFSTREAM UROLOGY

Date:_____/_____/20_____

PLEASE INDICATE ANY CHANGES ON THE BACK OF FORM

Note: This is a confidential record and will be kept at your doctor's office

Medical History
(Date of Onset)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Current Medications
(Dosage/Strength/Frequency)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Family History (List any diseases of Immediate Family Members)

1._____
2._____
3._____
Mother Alive Deceased Age___
Father Alive Deceased Age___

Social History
Do you smoke? ☐ Yes ☐ No
If yes, How much?_____
Total **#Years** Smoking?_____
Former Smoker? ☐ Yes ☐ No
Quit Date:_____
Total **#Years** Smoked?_____

Drink Alcohol? ☐ Yes ☐ No
How Much?_____
#Years_____

PHARMACY NAME:

_____

Medical History
(Date of Onset)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Current Medications
(Dosage/Strength/Frequency)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Family History of Prostate Cancer

☐ Yes ☐ No

Relation to You: _____
_____
_____
_____

Occupation (What you do or did for a living?)

_____
_____
_____

Where are you from originally?

_____
_____
_____

Pharmacy Phone Number:

_____

SUBSEQUENT APPOINTMENTS:
Medical History Changes
(Patient Date/Initial)

1. ☐ No Change_____
2. ☐ No Change_____
3. ☐ No Change_____
4. ☐ No Change_____
5. ☐ No Change_____
6. ☐ No Change_____
7. ☐ No Change_____
8. ☐ No Change_____
9. ☐ No Change_____
10. ☐ No Change_____

SUBSEQUENT APPOINTMENTS:
Medication Changes
(Patient Date/Initial)

1. ☐ No Change_____
2. ☐ No Change_____
3. ☐ No Change_____
4. ☐ No Change_____
5. ☐ No Change_____
6. ☐ No Change_____
7. ☐ No Change_____
8. ☐ No Change_____
9. ☐ No Change_____
10. ☐ No Change_____

ALLERGIES

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

What is the main reason for your visit today? _____
_____
_____
_____
_____
_____
_____

Please indicate any changes to your medical history or medications below and date/initial the changes

Medical History Changes

1._____ Date/Initial _____
_____
2._____ Date/Initial _____
_____
3._____ Date/Initial _____
_____
4._____ Date/Initial _____
_____
5._____ Date/Initial _____
_____
2._____ Date/Initial _____
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3._____ Date/Initial _____
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4._____ Date/Initial _____
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5._____ Date/Initial _____
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6._____ Date/Initial_____
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7._____ Date/Initial_____
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8._____ Date/Initial_____
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9._____ Date/Initial_____
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10._____ Date/Initial_____
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11._____ Date/Initial_____
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12._____ Date/Initial_____
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13._____ Date/Initial_____
_____
14._____ Date/Initial_____
_____

Medication Changes

1._____ Date/Initial _____
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2._____ Date/Initial _____
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3._____ Date/Initial _____
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4._____ Date/Initial _____
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5._____ Date/Initial _____
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2._____ Date/Initial _____
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3._____ Date/Initial _____
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4._____ Date/Initial _____
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5._____ Date/Initial _____
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6._____ Date/Initial_____
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8._____ Date/Initial_____
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9._____ Date/Initial_____
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10._____ Date/Initial_____
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11._____ Date/Initial_____
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12._____ Date/Initial_____
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13._____ Date/Initial_____
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14._____ Date/Initial_____
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