Lansing Institute of Urology

Patient Information Form

Patient Name: _____D.O.B._____ Gender Select

Family Dr.: _____

Reason for seeing the doctor today:_____

For established patients only: Have you had any recent changes in medical history? ☐Yes ☐No

(*if yes please indicate changes below)*

YES	NO	Medical History (Check only chronic symptoms or conditions)	If YES, explain below
☐	☐	Kidney stones	_____
☐	☐	Recurrent UTI	_____
☐	☐	Kidney, Bladder, or Prostate Problems	_____
☐	☐	Genital Problem	_____
☐	☐	STD, HIV	_____
☐	☐	Heart Attack, or Heart Condition	_____
☐	☐	Lung Problems, asthma, TB or chronic pneumonia	_____
☐	☐	Liver Problems, Jaundice, Hepatitis	_____
☐	☐	Diabetes	_____
☐	☐	High Blood Pressure, or vascular disease	_____
☐	☐	Seizures, Stroke, or Convulsions	_____
☐	☐	Bleeding Problems, Anemia	_____
☐	☐	Stomach Ulcers, other bowel problems	_____
☐	☐	Emotional or Psychiatric Problems including Depression	_____
☐	☐	Chronic Headaches, Migraine, or Fainting	_____
☐	☐	Arthritis	_____
☐	☐	Glaucoma, or cataracts	_____
☐	☐	Previous Blood Transfusions	_____
☐	☐	Cancer of any kind	_____
☐	☐	Do you take blood thinners?	_____
☐	☐	Do you take Aspirin on a daily basis?	_____
☐	☐	Do you take antibiotics prior to procedures?	_____

Surgical History

☐**No Past surgeries**

Year	Surgery	Year	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications

☐**No Medications**

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies (medication, IV contrast, Foods, and Environmental, etc…)

☐ **No Know Allergies**

_____ _____

_____ _____

_____ _____

Social History

Tobacco ☐ **YES** ☐ **NO** **Type**_____ **Amount**_____ **pks/day** **Duration**_____**Years**

Alcohol ☐ **YES** ☐ **NO** **Socially/ Frequently/ Daily** **Amount**_____

Recreational Drugs (including medical marijuana) **YES** **NO** _____

Caffeine ☐ **YES** ☐ **NO** **Amount**_____

Family History (Check if someone in your family has a history of one of these)

YES	**NO**		**If Yes how are they related to you? Provide Details**
☐	☐	Prostate Cancer	_____
☐	☐	Kidney Bladder or Other Urological Cancer	_____
☐	☐	Kidney stones	_____
☐	☐	Diabetes, Hypertension, Heart Attack,	_____
☐	☐	Stroke	_____

Review of Symptoms (Please check any that may apply):

Ears and Hearing: ☐ Loss of Hearing ☐ Buzzing ☐ Ringing ☐ Ear Infections

Nose and Throat: ☐ Hoarseness ☐ Difficult swallowing ☐ Nose bleeds ☐ Frequent Sneezing ☐ Frequent URI

Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Coughing ☐ Use of Oxygen

Cardiovascular: ☐ Chest Pain ☐ Abnormal Heartbeats ☐ Swelling of the feet or ankles ☐ Varicose veins

Gastrointestinal: ☐ Abdominal Pain ☐ Nausea/Vomiting ☐ Loss of Appetite ☐ Diarrhea ☐ Constipation ☐ Blood in stools

Genitourinary: ☐ Problems Urinating ☐ Blood in urine ☐ Incontinence ☐ Sexual Dysfunction ☐ Frequency ☐ Urgency

Skin: Itching ☐ Rash ☐ Open Sores or Wounds

Musculoskeletal: ☐ Joint Pain ☐ Joint swelling ☐ Difficulty walking ☐ Back Pain ☐ Bone Pain ☐ Arthritis

Neurological: ☐ Headaches ☐ Dizziness ☐ Seizures ☐ Numbness ☐ Blackouts ☐ Lapse in Memory

Psychological: ☐ Depression ☐ Excessive Stress ☐ Hopelessness ☐ Anxiety

Reset Form **Print Form**