a division of
Clear Lake Specialties
New Patient Information

Today's Date:_____ Doctor's Name:_____

Patient's Name: _____ Date of Birth: _____

Patient History

Reason for today's visit: _____

_____

Medications

Please list the name, dosage, and how often you take the medication.

Please include IV antibiotics, nebulizer medications, vitamins, over the counter and prescription meds.

1)_____ 11)_____

2)_____ 12)_____

3)_____ 13)_____

4)_____ 14)_____

5)_____ 15)_____

6)_____ 16)_____

7)_____ 17)_____

8)_____ 18)_____

9)_____ 19)_____

10)_____ 20)_____

Allergies

1) Medications:_____

_____

2) Food: _____

_____

3) Other: _____

_____

HTX Urology

a division of
Clear Lake Specialties
New Patient Information

Please let us know if you have been diagnosed with any of the following:

- ☐ Anemia
- ☐ Angina Aortic Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain/injury
- ☐ Bleeding Disorders
- ☐ Blood clots in the legs or lungs
- ☐ Bronchitis
- ☐ Cancer; where?

  _____
- ☐ Cirrhosis of the liver
- ☐ Compression fracture
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombus
- ☐ Depression/Nervous disorder
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Eye Problems
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Goiter/thyroid disorder
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Problems, Other
- ☐ Hepatitis
- ☐ Hernias, Hiatal or Other
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney stones
- ☐ Kidney/Bladder infection
- ☐ Migraine headaches
- ☐ Osteoporosis (thinning of bones)
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Prostate enlargement
- ☐ Prostate infection
- ☐ Psychiatric Illness
- ☐ Pulmonary Embolus
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TB Tuberculosis
- ☐ Lung Problems, Other
- ☐ Ulcers
- ☐ Urinary Problems

Women Only

- ☐ Currently on birth control pills
- ☐ Recurrent Vaginitis
- ☐ Endometriosis
- ☐ Ovarian cysts or tumors
- ☐ Pelvic Infection
- ☐ Menstrual Disorders
- ☐ Recent Miscarriages

OTHER: If there are other illnesses not listed here, please write them in the space below:

_____
_____
_____
_____
_____
_____

Please tell us if you have had any of the following surgeries and list the date of each one.

- ☐ Lungs/ Chest: What kind? _____ Date: _____
- ☐ Heart: What kind? _____ Date: _____
- ☐ Abdominal: What kind? _____ Date: _____
- ☐ Gallbladder: _____ Date: _____
- ☐ Appendix: _____ Date: _____
- ☐ Hernia: _____ Date: _____
- ☐ Eyes: _____ Date: _____
- ☐ Prostate: _____ Date: _____
- ☐ Hysterectomy: _____ Date: _____
- ☐ Mastectomy: _____ Date: _____
- ☐ C-Sections: _____ Date: _____
- ☐ Others: _____ Date: _____

_____

Hospitalizations: Have you ever been hospitalized for any reason? Please explain and list the dates

Date:_____ Reason: _____

Date:_____ Reason:_____

Date: _____ Reason: _____

Date:_____ Reason: _____

Date:_____ Reason: _____

Date:_____ Reason: _____

Immunizations/ Vaccines: When was the last time you had the following vaccines:

Pneumonia: _____ Flu Shot: _____

Hep A:_____ Tdap: _____

Hep B: _____ Other: _____

Did any blood relatives (parents, grandparents, children, brothers, or sisters) have any of the following if yes, please list who had the illness.

☐ Asthma _____

☐ Tuberculosis _____

☐ Heart Disease _____

☐ Diabetes _____

☐ Hypertension _____

☐ Lung Disease _____

☐ Cancer _____

☐ Stroke _____

☐ Excessive Bleeding _____

☐ Thyroid _____

☐ Arthritis _____

☐ Glaucoma _____

☐ Others _____

☐ **Family History of Urology Cancer**: ( ) None ( ) Prostate ( ) Kidney ( ) Bladder ( )Testicle

_____

_____

Social History

Did you ever smoke cigarettes, cigars, or pipes?

How many packs per day _____ How many years?_____ Age quit?_____

Did you ever drink alcohol? If so, what type?

How many drink per week_____ How many years?_____ Age quit?_____

Who do you live with? _____

Do you have any pets? What kind?_____

What jobs/occupations have you had during your lifetime?_____

_____

Were you ever exposed to excessive dust, asbestos, sand etc? _____

_____

Have you travelled outside the US? If so, when? _____