

Somerset Urological Associates

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MEDICAL HISTORY: Please Check

	Yes	No		Yes	No
Heart Disease	_____	_____	Stroke/Parkinson's/MS	_____	_____
Diabetes	_____	_____	Lung Disease/Asthma	_____	_____
Hepatitis/Liver Dis	_____	_____	Cancer	_____	_____
HIV/AIDS	_____	_____	Other _____		

SURGICAL HISTORY: Please list & kindly include the date

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

FEMALE HISTORY: (IF APPLICABLE)

Last Menstrual Period _____

Total Number of Pregnancies _____ Pregnancies to Full Term _____

Total Number of Vaginal Deliveries _____ Cesarean Deliver _____

FAMILY HISTORY:

	Alive	Deceased	Cause of Death (if applicable)
Father:	_____	_____	_____
Mother:	_____	_____	_____

SOCIAL HISTORY:

Marital Status: _____ Number of Children: _____ Occupation: _____

Alcohol Consumption: (Yes) _____ (No) _____ Amt per Day _____

Tobacco Use: (Yes) _____ (No) _____ Packs per Day _____

Caffeinated Beverages (Yes) _____ (No) _____ Amt per Day _____