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Patient History Form

Today's Date ____/____/____ Date of last physical exam ____/____/____
 Last name _____ First Name _____ Middle _____
 DOB ____/____/____

What is the main reason for the visit today? (Please describe the problem in detail) _____

Past medical and social history

List all illnesses in your immediate family. (Example: diabetes, tuberculosis, cancer, heart disease, etc.) _____

List any personal past illnesses and/or surgeries and when they occurred. _____

Do You Smoke? ___ Yes ___ No How Much? ____ Do you Drink? ___ Yes ___ No How Much? _____

Please list all current medications: _____

Are you on a special diet? ___ Yes ___ No If yes explain: _____

Do you have allergies? ___ Yes ___ No Example: Penicillin, Sulfa, Any foods, etc. If yes explain: _____

Describe your job: _____

For Children Patients Only

Is this on behalf of your child? ___ Yes ___ No **Child's Name** _____

Are immunizations current? ___ Yes ___ No

Has your child or does your child have the following? Please check all that apply ___ Asthma ___ Diabetes
 ___ Rheumatic Fever ___ Epilepsy ___ Other illnesses _____