Jerry Weinberg, MD
Westchester Health Urology
666 Lexington Avenue, Suite 100
Mt. Kisco, NY 10549

Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Examination: _____

PAST MEDICAL HISTORY:

Have you had any of the following (please circle yes or no)

Do you wear a pacemaker?	Yes	No
Heart Attack	Yes	No
Hypertension (high blood pressure)	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Gallbladder disease	Yes	No
Ulcer disease	Yes	No
Asthma	Yes	No

Any other conditions (please list):

_____

_____

Please list all previous surgery:

_____

_____

Do you smoke: Yes No If yes, how many packs per day? _____

Do you take aspirin? Yes No If yes, how much? _____

DO you take any medications? Yes No If yes, please list all of your medications with dosage:

_____

_____

_____

Do you have allergies? Yes No If yes, please list them:

_____

FAMILY HISTORY:

Does/did any member of your immediate family have kidney stones? Yes No

If so, who? _____

Does/did anyone in your family have kidney disease? Yes No

If so, who? _____

Does/did anyone in your family have kidney or bladder cancer? Yes No

If so, who? _____

Does/did anyone in your family have prostate cancer? Yes No

If so, who? _____

Does/did anyone in your family have testicular cancer? Yes No

If so, who? _____

Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Have you recently lost weight without dieting?	Yes	No
Do you have glaucoma?	Yes	No
Do you have a heart murmur?	Yes	No
Do you have emphysema or chronic bronchitis?	Yes	No
Do you have gastrointestinal disorders such as Crohn's Disease or Ulcerative colitis? If so, which one? _____	Yes	No
Do you have any bone or joint disease?	Yes	No
Do you have eczema or psoriasis?	Yes	No
Are you suffering from depression or schizophrenia?	Yes	No
Do you drink alcohol?	Yes	No
If yes, how much? _____		
Do you have any bleeding disorders?	Yes	No
If so, which one? _____		

UROLOGIC HISTORY

Do you get up at night to urinate? If yes, how many times? _____	Yes	No
Have you seen blood in your urine?	Yes	No
Are you urinating more frequently?	Yes	No
Is there pain on urination?	Yes	No
Do you feel like you empty your bladder when you go to the bathroom?	Yes	No
Can you suppress the urge when you need to void?	Yes	No
Do you lose urine when you cough or sneeze?	Yes	No
Have you ever had urinary tract infections?	Yes	No
Have you ever had kidney stones?	Yes	No

Referring Physician: _____

Primary Care Physician: _____

Pharmacy Name: _____

Pharmacy Town and Telephone Number: _____

_____

Thank you.