Dan Hibbert Urology

New Pt

Name:_______________________________ DOB:_________ Date:_________

Reason For Today's Visit:____

Primary Care Physician: ____

Preferred Pharmacy: ____

All Medications you are taking:____

Aspirin: ❑yes ❑no ____

Allergies: ____

____

Imaging (CT, X-rays, Ultrasound etc) or Labs (Urine, PSA) Pertaining to this visit:

What?___________ When?________________ Where?__________________

Medical Conditions: ____

____

Surgeries: ____

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Are you currently pregnant?___ How many weeks?____ Date of LMP:_________

Are you currently married?______ Do you have children? _____ How many?____

What is your current occupation?_______________________________________

Alcohol Usage:❑Current or ❑Past or ❑None? How Much?____ How Often?_____

Tobacco Usage: ❑Current or ❑Past or ❑None? How Much? ___ How Often? ____
How long ago?___________ How much and how often? ____________________

Recreational Drugs: ❑Current or ❑Past or ❑None? What form?______________

Anything else we need to know:____

<u>For Office Use Only:</u>
Notes:

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