

UNIVERSITY UROLOGY ASSOCIATES  
Telephone (212) 686-9015 Fax (212) 686-8607

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Home address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email address: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_ Company \_\_\_\_\_ Marital Status \_\_\_\_\_

**MEDICAL HISTORY** (please use back of page to supply any additional information for the following)

Medication/Food Allergies: \_\_\_\_\_

Previous Illnesses (with dates) \_\_\_\_\_

Previous Surgeries (with dates) \_\_\_\_\_

**CURRENT MEDICATIONS, VITAMINS AND/OR SUPPLEMENTS**

Medication Name	Dose/frequency of medication?	When did you start taking this?	Are you still taking this medication?	Why are you taking this medication?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

