MIAMI UROLOGY®
& SEXUAL WELLNESS INSTITUTE

Personal History

Date: _____

Patient Full Name: _____ Age: _____

Party responsible for providing this information: _____

Party responsible for providing transportation: _____

Physical/Sensory Limitations or Restrictions: _____

Check all that apply: ☐ Glasses ☐ Contacts ☐ Dentures ☐ Loose Teeth ☐ Capped Teeth
☐ Broken Teeth ☐ Missing Teeth ☐ Hearing Aid/Hearing Deficit

Have you had prior surgery or a major illness within last 5 years?: ☐ Yes ☐ No

Have you had any anesthesia? ☐ Yes ☐ No If yes, please list dates: _____

Have you ☐ or anyone in your family ☐ ever had an unusual reaction to anesthesia? ☐ Yes ☐ No

If so, what was the reaction? _____

Do you have any implants? ☐ Knee ☐ Hip ☐ Pacemaker ☐ Other: _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Occasionally

If yes, what kind: _____ How many drinks per week?: _____

Do you use tobacco? ☐ Yes ☐ No If yes, number of years used: ____ *or* year quit: ____

If yes, what kind? ☐ Cigarettes: Pks./day ___ ☐ Chew: #/day ___ ☐ Pipe: #/day ___ ☐ Cigars: #/day ___

Are you on a special diet? ☐ Yes ☐ No

<u>WOMEN</u>: Are you pregnant? ☐ Yes ☐ No LMP: _____

Do you lead a lifestyle that puts you at risk for HIV or Hepatitis B? ☐ Yes ☐ No

Last Physical Exam: Date: _____ Physician: _____

STAFF USE ONLY

Physician Name: _____ Cardiac clearance: ☐ Yes ☐ No

Vitals: Height: _____ Weight: _____ Resp. Rate: _____ Temp: _____ BP: _____ Pulse: _____

Diagnosis: _____

Procedure Date: _____ Post Op Date: _____