MEDICAL INFORMATION

Personal History (Please check all that apply)

YES	NO	
___	___	Prostate Cancer
___	___	Kidney Disease
___	___	Diabetes
___	___	Heart Disease
___	___	Alcohol Use
___	___	Smoking

If YES, explain below
___________packs per day, for ________ years

YES	NO	
___	___	Bladder Cancer
___	___	Kidney Stones
___	___	High Blood Pressure
___	___	Stroke
___	___	Recreational Drug Use
___	___	Depression or Mental Illness
___	___	Arthritis

Past Surgical History

Please list all surgeries you have had including the dates:

____ **Approximate Date** ____________
____ **Approximate Date** ____________
____ **Approximate Date** ____________
____ **Approximate Date** ____________
____ **Approximate Date** ____________

Current Medications and Vitamins

Name	Strength	How often?

Do you have any medication allergies? Yes No
(If yes, please list allergies including their side affect)

____
____
____

Preferred Pharmacy:

Name ____________________ Address: ______________________ Phone (____) ______________