Nebraska Urology Health History

Name:	DOB:	Ht:	Wt:

Current Gender:	Gender Identity:	Preferred Pronoun:

REASON FOR VISIT:	Pharmacy Name & Address:

Have you had a flu shot? NO YES When? _____ **Pneumonia Vaccination?** NO YES When?_____

List all **CURRENT MEDICATIONS** and dose including over-the-counter, aspirin meds, fish oil, inhalers and vitamins. ☐ **None**

List all **ALLERGIES** to **medications** and your **reactions**. ☐ **None**

Allergy	Reaction	Allergy	Reaction
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown

Allergy to Latex? NO YES

Have you had a reaction to or do you have an allergy to iodine? NO YES

Have you ever had an antibiotic resistant infection

such as MRSA, VRE or CRE? NO YES if Yes circle, ACTIVE HISTORY OF

Please list all **SURGERIES** in the last year. ☐ **None**

Surgery	Surgery

Tobacco Use: (please circle) Never Current Former Age Quit? _____

Type: Cigarettes Cigar Pipe Smokeless How much daily? _____

Diabetes: NO YES If yes, do you take medication for this? NO YES	**Heart Disease (bypass stent, surgery):** NO YES	**High Blood Pressure:** NO YES

Have you ever had Total or Partial Joint Replacement NO YES

If yes, What joint? _____ When was surgery?_____

If yes, have you been told to take antibiotics prior to surgery or dental procedures? NO YES

Signature/Form Completed by: _____ Date: _____