Patient Name: _____ **DOB:** _____

Patient Social History:

Occupation: _____

Marital Status:	___Single	___Married	___Separated	___Divorced	___Widowed
Use of Alcohol:	___Never	___Rarely	___Moderate	___Daily	Drinks/wk (Whiskey, Beer +/or Wine) _____
Use of Tobacco:	___Never	___Rarely	Previously, but quit, when?: _____		Currently packs/day_____ Years _____
Use of Drugs:	___Never	___Rarely	Previously, but quit, when?: _____		
Excessive exposure at home or at work:			____Fumes ____Dust	____Solvents	____Airborne particles ____Noise

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please list your current medications (or give receptionist a printed list to copy)

Medication	Dosage	Times per day

Pediatric urology group
A division of Peoria Surgical Group