Pacific Rim Urology
Dr. Mansel K. Kevwitch
1730 E. Division St.
Mt. Vernon, WA 98274

ADULT HEALTH HISTORY FORM

PATIENT NAME: _____ **DATE:** ____/____/_____ **MED REC #:**_____
DATE OF BIRTH: ____/____/_____ **AGE:** _____ **HEIGHT:** _____FT _____IN **WEIGHT:** _____LBS
Name of Referring Physician: _____ Referring Physician's Phone #:_____
Referring Physician's Address: _____
Primary Care Physician (if Different)_____ Phone #:_____
Race: ☐White ☐Black ☐Hispanic/Latino ☐Asian ☐Other: _____ Sex: ☐Female ☐Male
Reason for your visit today: _____

Pharmacy Name: _____ **Address:** _____ **City:**_____ **Zip:**_____
Pharmacy Phone #:_____ **Pharmacy Fax #:** _____

Drug Allergies: _____
Other Allergies:_____

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely:

Name of Drug or Supplement:	Strength (mg):	How often (# of times per day)

MEDICAL HISTORY: Please check any of the following conditions which **YOU** have had or presently have:

☐Anemia	☐Chronic UTIs	☐Hepatitis C	☐Neurologic disease	☐Sickle Cell disease
☐Chest Pain	☐Congestive Heart Failure	☐Hypercholesterolemia	☐Osteoarthritis	☐Thyroid disease
☐Arthritis	☐COPD	☐Hyperlipidemia	☐Osteoporosis	☐Kidney stones
☐Asthma	☐Coronary Artery Disease	☐High Blood Pressure	☐Parkinson's Disease	☐Valvular heart disease
☐BPH	☐Depression	☐Inflammatory bowel	☐Peptic Ulcer disease	
☐Cancer-Type:_____	☐Diabetes	☐Liver disease	☐Peripheral vascular disease	
	☐Diverticular disease	☐Lupus	☐Renal/Kidney disease	
_____	☐GERD	☐Migraine headaches	☐Rheumatoid arthritis	
☐CVA (Stroke)	☐Gout	☐Heart Attack	☐Seizure disorder	

♀ **FEMALES ONLY: Date of last Menstrual Period:** ____/____/_____ **Date of last PAP Smear:** ____/____/_____ ♀

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure

	Yr		Yr		Yr	♀ Females Only	Yr	♂ Males Only	Yr
☐Adrenalectmy		☐Cystoscopy		☐Liver biopsy					
☐Appendectmy		☐ESWL		☐Kidney removed		☐Bladdr suspnsn		☐Brachytherapy	
☐Back Surgery		☐Gastic bypass		☐Pacemaker		☐Breast biopsy		☐Circumcision	
☐Bladder Augumentn		☐Hernia repair		☐Perc stone removal		☐C-Section		☐Hernia Repair	
☐CABG		Type:		☐Kidney stone removal		☐Abd Hyst		☐Hydrocelectomy	
☐Gall Bladder				☐Ureteral Stents Plcd		☐Mastectomy		☐Laser of Prostate	
☐Colectomy		☐Hip replacement		**Other:**		☐Vaginal Sling		☐Orchiectomy	
☐Colon surgery		☐Knee replacemnt		☐		☐TAH / BSO		☐Penile Prosthesis	
☐Coronary stent		☐Laparoscopy		☐		☐Tubal ligation		☐Prostate Biopsy	
☐Bladder removal		☐Lithotripsy		☐		☐Vaginal Hyst		☐Prostatectomy	
								☐Spermatocelectomy	
								☐TURP	
								☐Varicocele ligation	
								☐Vasectomy	