Entrust Medical Group
Urology and Urologic Surgery
William F. Pearce, M.D.
Hari Sawkar, M.D.

Patient Name: _____

Date of Birth: _____

Primary Care Provider: _____

Patient Summary Form

Preferred Pharmacy Name & Phone # _____ Drug Allergies/Sensitivities: _____

REASON FOR THIS APPOINTMENT

Chronic Medical Problem List	Date	Past Surgical History	Date
		Hospitalizations	**Date**
Medications			

Family History of

Y	N		Family Member
☐	☐	Alzheimer's Dz	_____
☐	☐	Breast Ca	_____
☐	☐	CAD	_____
☐	☐	Cerebrovas, Dz	_____
☐	☐	Cervical Cancer	_____
☐	☐	Colon CA	_____
☐	☐	Depression	_____
☐	☐	DM	_____
☐	☐	Fe Storage	_____
☐	☐	Glaucoma	_____
☐	☐	Hyperchol.	_____
☐	☐	HTN	_____
☐	☐	Ovarian CA	_____
☐	☐	Prostate CA	_____
☐	☐	Skin CA	_____
☐	☐	Thyroid Dz	_____

Social History

☐ Married ☐ Single ☐ Separated

☐ Divorced ☐ Widow(er)

Number of Children _____ (M/F)

Occupation: _____

Religious Preference: _____

Advance Directive? ☐ Yes ☐ No

If Yes, Date: _____

Educ.: ☐ JHS ☐ HS ☐ College

☐ Other _____

Signature: _____ Date: _____

POS Reorder # 1901126