

MEDICAL HISTORY

Name _____ DOB _____ Date _____

Pharmacy & phone Number _____

Reviewed with Patient _____ nothing new since last visit dated: _____

Current Physicians: Address _____ Phone# _____ Specialty _____

1. _____

2. _____

3. _____

Name of physician who referred you to this office _____

MEDICATIONS (List all prescription drugs you are taking with dosage and schedule):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

List all non-prescription drugs:

Vitamins _____

Antacids _____ How often: occasionally daily

Supplements _____

Aspirin/Ibuprofen _____ How often? _____

Others _____

ALLERGIES (List all allergies to drugs or foods (i.e. sulfa, shellfish)) No known allergies

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

CHIEF COMPLAINT: (Why do you want to see the doctor?)

How long have you had this complaint? _____

SOCIAL HISTORY

Marital status: S M W D # children _____ ages _____

Occupation _____ Previous occupations _____

Tobacco use? Yes No Daily amount _____ppd Type _____

Prior tobacco use: How long? _____ When did you quit? _____

Alcohol use? Yes No How many drinks in an average week? _____

Caffeine use? Coffee cups/day _____ tea cups/day _____ cola cans/day _____ chocolate Y N

Dietary sweeteners? NutraSweet (Aspartame) ___ Equal ___ SugarTwin ___ Sweet & Low (Saccharin) ___

PATIENT HISTORY

Medical History

No Medical Problems

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Lung Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver Disease/Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis/Gout	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding tendency	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Depression
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mental Illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Alcoholism
Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epilepsy/Seizure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Drug abuse
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis			

Other medical problems _____

Previous hospitalizations for medical problems: No Yes, if yes type and date: _____

Previous Surgeries No Yes, if yes type and date: _____

Please complete reverse side of sheet

FAMILY HISTORY (Check illnesses which has occurred in any blood relative and write relationship to you):

<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Urinary tract infection	<input type="checkbox"/> Kidney Stones	

REVIEW OF SYSTEMS: (Do you now have or have you ever had:)

Significant weight change? Y N Loss or Gain? Y N #of lbs _____ Follow up: none

Any eye disease, injury, impaired sight?	Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/> Ref to PCP
Any ear disease, injury, impaired hearing?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Any trouble with nose, sinuses, mouth, throat?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Bleeding gums?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Trouble Swallowing?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Chest pain or tightness in the chest?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiating down arm?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Shortness of breath?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Burning pain on urinating?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Coughing up blood?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of control of bladder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Night sweats?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood in urine?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Palpitations?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Frequent urination?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Swelling of hands or feet?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have trouble with erections?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weakness in arm or leg?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have painful intercourse?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Varicose veins?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Paralysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stomach trouble or ulcer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Enlarged glands?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Constipation or diarrhea?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Enlarged thyroid or goiter?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hemorrhoids or rectal bleeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pain in joints or gout?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting spells?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin irritation or rashes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Loss of consciousness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Depression or anxiety?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Spells of dizziness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hallucinations?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Convulsions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Breast lumps?	
Frequent or severe headaches?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Menstrual irregularities?	

Last Gyn exam/PAP test (date) _____

Additions: _____

PAST UROLOGIC HISTORY (Check where appropriate)

Urinary Tract Infections Yes No
 Type: Bladder/cystitis _____ Kidney _____
 Frequency: Less than once a year Several times a year Has involved high fever and Flank pain
 Has been previously evaluated by whom and where? _____
 History of Venereal Disease Yes No Date _____ Treatment _____
 History of Prostatitis Yes No Date _____ Treatment _____
 History of Urinary Stones Yes No Kidney Stones Yes No Bladder Stones Yes No
 Urinary Tract Cancer Yes No
 Kidney Testis Prostate Bladder Adrenal Glands
 Sexual Dysfunction Yes No
 Decreased desire for sex Decreased frequency of erections Trouble maintaining erections
 Premature ejaculation Painful erection Painful intercourse
 Previous urologic procedures Yes No
 Surgery for kidney stones Surgery for enlarged prostate Surgery for urinary cancer
 Surgery for urinary tract infections or reflux

Form completed by: _____ Reviewed by: _____ Date: _____