

Name: _____ Date: _____

Referring Doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

CURRENT MEDICATIONS - Please list ALL medications you are currently taking including over the counter meds

| Drug Name: | Strength:Directions/How you take it: | |
|------------|--------------------------------------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Attach list if necessary

Pharmacy Name: _____ Phone #: _____

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods)

By what method did you choose our practice:

_____Referring Physician _____Friend _____Yellow Pages _____Insurance Company _____Other, please list_____

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

_____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Life Partner _____ Common Law Spouse

Dependants: Please indicate # of each, if you have:

_____ Sons _____ Daughters _____ Stepchildren _____ Adopted _____ Foster _____ Parents _____ Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired,
Other_____

Hobbies: Please circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball, Other _____

Alcohol Consumption:

_____ None _____ Yes Occasional/Social # of drinks per day _____

Tobacco per day:

_____ None _____ Yes # _____ Packs/day _____ Cigarettes/day _____ Smokeless Tobacco

If you previously stopped, when? _____

Recreational Drugs: _____ None If yes, please list: _____

Caffeinated beverages: None Low Moderate Excessive

Recent Foreign Travel: None Americas _____ Worldwide _____

REVIEW OF SYSTEMS:

Constitutional

Appetite Changes
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Swollen Glands
Weight Gain
Weight Loss

Eyes

Blind
Blurred Vision
Double Vision
Glaucoma
Pain
Worsening Eyesight

Allergic/Immunologic

Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

Neurological

Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems

Tremors

Endocrine

Diabetes
Excessive thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold

Gastrointestinal

Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular

Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Orthopnea
Pain/Cramps Hips/Legs w/exercise
Palpitation

Skipped Heart Beats
Swelling

Skin

Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

Musculoskeletal

Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

Ear/Nose/Throat

Ear Infection
Sinus Problem
Sore Throat

Genitourinary

Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying

Painful Ejaculation
Pregnant (currently)
Stranguria
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream

Respiratory

Asthma
Emphysema–Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of breath
Tuberculosis
Wheezing

Hematological/Lymphatic

Swollen Glands
Blood clotting problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

Psychologic

Anxiety
Depressed
Generally satisfied with life

Other: -----

Name: _____ Date: _____

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular

- Anemia
- Angina
- Aortic Aneurysm
- Aortic Regurgitation
- Aortic Stenosis
- Arrhythmia
- Atrial Fibrillation
- Bleeding Disorder
- Cardiomyopathy
- Cerebrovascular Disease
- Congenital Heart Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Deep Vein Thrombosis
- Endocarditis
- Heart Attack
- Heart Disease
- Heart Murmur
- Heart Valve Problem
- Hemophilia
- Hypertension, well controlled
- Hypertension, progressive
- Hypertension, severe
- Mitral Insufficiency
- Mitral Stenosis
- Mitral Valve Prolapse
- Rheumatic Fever
- Sickle Cell Anemia
- Stroke
- Thrombophlebitis
- Ventricular Arrhythmia

Endocrine/Metabolic

- Diabetes Mellitus, non-insulin dependent
- Diabetes Mellitus, insulin dependent
- Diabetes Mellitus, uncontrolled
- Goiter
- Gout
- Hyperthyroidism
- Hypothyroidism

General

- Allergies
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Hypercholesterolemia
- Hyperlipidemia
- Malaise

- Obesity
- Paget's Disease
- PCKD
- PCO
- Raynaud's Syndrome
- Sleep Apnea

GI

- Cholecystitis
- Cholelithiasis
- Chronic Liver Disease
- Colitis
- Constipation
- Colon Condition
- Crohn's Disease
- Diarrhea
- Diverticulitis
- Diverticulosis
- GERD
- Hemorrhoids
- Hepatic Failure
- Hepatitis
- Hiatal Hernia
- Inflammatory Bowel Disease
- Liver Disease
- Pancreatitis
- Peptic Ulcer (Duodenal)
- Rectal Fissure
- Stomach Ulcer
- Ulcerative Colitis

GU

- AIDS
- Bladder Stone
- Bladder Infection
- Chronic Renal Disease
- Chronic Renal Insufficiency
- Chronic Renal Failure
- Hematuria
- Impotence
- Interstitial Cystitis
- Irradiation Therapy
- Kidney Cancer
- Kidney Disease
- Kidney Infection
- Kidney Stones
- Libido Decreased
- Nephrolithiasis
- Nephrotic Syndrome
- Neurogenic Bladder
- Orchitis
- Penile Discharge
- Polycystic Disease

- Polycystic Kidney Disease
- Prostate Cancer
- Radiation or Nuclear Exposure
- Recurrent UTI
- Renal Cell Cancer
- Renal Failure
- Renal Insufficiency
- Testicular Cancer
- Transplant Recipient
- Transitional Cell CA Bladder
- Transitional Cell CA Ureter
- Undescended Testicle (Birth)
- Urinary Tract Infection
- Venereal Disease

GYN/OB

- Breast Cancer
- Endometriosis
- Menopause
- Menstrual Problems
- Osteoporosis
- Ovarian Cancer
- Pregnancy - #_____ Deliveries #_____ C-sections #_____
- Uterine Fibroids

HEENT

- Blindness
- Cataracts
- Deviated Septum
- Deafness
- Ear Infections
- Glaucoma
- Hay Fever
- Menniere's
- Mumps
- Sinusitis
- Tinnitus
- Vertigo

Musculoskeletal

- Arthritis
- Back Pain
- Carpal Tunnel Syndrome
- Fibromyalgia
- Morton's Neuroma

Neurological/Psychological

- ADD
- ADHD
- Alcoholism

- Alzheimer's disease
- Anxiety
- Bi-polar Disorder
- Chronic Fatigue Syndrome
- Depression
- Eating Disorder
- Epilepsy
- Herniated Disc
- Mental Illness
- Migraine
- Multiple Sclerosis
- Organic Brain Syndrome
- Parkinson's
- Polio
- Seizures
- Spinal Cord Injury
- Stroke

Respiratory

- Asthma
- Bronchitis
- Chronic Lung Disease
- COPD
- Emphysema
- Lung Disease
- Pneumonia
- Pulmonary Embolism
- Tuberculosis

Tumors

- Brain Cell Carcinoma
- Brain Tumor
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Fibrocystic Breast Disease
- Gastric Cancer
- Laryngeal Cancer
- Lung Cancer
- Lymphoma
- Melanoma
- Ovarian Cancer
- Pancreatic Cancer
- Prostate Cancer
- Rectal Cancer
- Rectal Cell Cancer
- Sarcoidosis
- Testicular Cancer
- Transitional Cell CA Bladder
- Transitional Cell CA Ureter
- Uterine CA

Other: _____

SURGICAL HISTORY

Please **CIRCLE** if you have had any of the following surgeries and date of surgery:

Cardiovascular

- Angioplasty
- Aortic Aneurysm Repair
- CABG
- Carotid Artery Surgery
- Heart Surgery
- Heart Surgery (Stents)
- Heart Transplant
- Pacemaker Insertion

- Liver Surgery
- Liver Transplant
- Lysis Adhesions
- Nissen Fundoplication
- Splenectomy
- Stomach Surgery
- Umbilical Hernia
- Ventral Hernia Repair

- Kidney Stone
- Laser Lithotripsy
- Meatotomy
- Needle Biopsy Prostate
- Nephrectomy
- Nephrolithotomy
- Orchiectomy
- Orchiopexy
- Penile Implant
- Penectomy
- Penile Surgery
- Pyeloplasty
- Radical Prostatectomy
- Renal Transplant
- Spermatoclectomy
- TUMT Prostate
- TUNA Prostate
- TURBT
- TUR Prostate
- Ureteroscopy
- Variocelectomy
- Vasectomy

- Septoplasty
- Sinus Surgery
- Tonsil Surgery
- Thyroid Surgery
- TMJ Surgery

General

- Brain Surgery
- Laminectomy
- Lymphatic Node Dissection
- Parathyroidectomy
- Pilonidal Cyst Incision
- Skin Grafting

GU

- Bladder Surgery
- Biopsy Prostate
- Brachytherapy
- Circumcision
- Contigen
- Cystoscopy
- Cystoscopy-Dilation
- Cystoscopy-Retrograde
- Cystoscopy-Stent
- Cysto-TUR Fulguration
- Durasphere
- Epididymectomy
- ESWL
- Herniorrhaphy
- Hydrocelectomy
- Hysterectomy -

- Penile Surgery
- Pyeloplasty
- Radical Prostatectomy
- Renal Transplant
- Spermatoclectomy
- TUMT Prostate
- TUNA Prostate
- TURBT
- TUR Prostate
- Ureteroscopy
- Variocelectomy
- Vasectomy

Musculoskeletal

- Amputation
- Arthroscopic Knee Surgery
- Back Surgery
- Carpal Tunnel Surgery
- Cervical Spine Surgery
- Disc Surgery
- Foot Surgery
- Hand Surgery
- Hip Surgery
- Knee Surgery
- Leg Surgery
- Rotator Cuff Surgery
- Shoulder Surgery

GI

- Appendectomy
- Bariatric Surgery
- Bowel Resection
- Cholecystectomy
- Colon Resection
- EGD
- EGD/Dilation Esophagus
- Fissurectomy
- Gastric Surgery
- Hemorrhoidectomy
- Ileostomy
- Laparoscopy

- Abdominal
- Vaginal
- Laparoscopic
- Ileal conduit
- Inguinal Herniorrhaphy
- Interstim

HEENT

- Cataract Surgery
- Corneal Surgery
- Ear Surgery
- Eye Surgery
- Facial Surgery
- Mastoid Surgery
- Nasal Surgery
- PEG

Respiratory

- Lung Surgery

Skin

- Basal Cell Carcinoma
- Melanoma
- Squamous Cell Carcinoma

Other: _____

FAMILY HISTORY

Please **CIRCLE** and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle , Aunt)

- Arthritis _____
- Bedwetting _____
- Bladder Cancer _____
- Cancer (site unknown) _____
- Crohn's Disease _____
- Depression _____
- Diabetes _____
- Gout _____
- Heart Attack _____
- Hypertension _____
- Kidney Cancer _____
- Kidney Stones _____

- Leukemia _____
- Malignant Melanoma _____
- Multiple Sclerosis _____
- Laryngeal Cancer _____
- Pancreatic Cancer _____
- Prostate Cancer _____
- Stroke _____
- Thyroid Disease _____
- Tuberculosis _____

Other: _____