

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 & Address: _____ 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_____

Race: _____American Indian _____Asian _____African American
 _____Asian
 _____White _____Middle East _____Other

Ethnicity:
 _____Hispanic or Latino
 _____Not Hispanic or Latino

Language: _____

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 # _____
Hysterectomy -
Abdominal
Vaginal
Laparoscopic
Uterine Fibroids

HEENT

Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Meniere'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

Name: _____

Date: _____

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

General

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

GI

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

Laparoscopy
Liver Surgery
Liver Transplant
Lysis Adhesions
Nissen Fundoplication
Splenectomy
Stomach Surgery
Umbilical Hernia
Ventral Hernia Repair
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatocectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelelectomy
Vasectomy

GU

Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelelectomy
Ileal conduit
Inguinal Herniorrhaphy
Interstim
Kidney Stone
Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant

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

Respiratory

Lung Surgery

Skin

Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

Name: _____ Date: _____

FAMILY HISTORY

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

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

- | | |
|-----------------------------|--------------------------|
| Arthritis _____ | Leukemia _____ |
| Bedwetting _____ | Malignant Melanoma _____ |
| Bladder Cancer _____ | Multiple Sclerosis _____ |
| Cancer (site unknown) _____ | Laryngeal Cancer _____ |
| Crohn's Disease _____ | Pancreatic Cancer _____ |
| Depression _____ | Prostate Cancer _____ |
| Diabetes _____ | Stroke _____ |
| Gout _____ | Thyroid Disease _____ |
| Heart Attack _____ | Tuberculosis _____ |
| Hypertension _____ | |
| Kidney Cancer _____ | |
| Kidney Stones _____ | |
| Other: _____ | |

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 _____

Name: _____ Date: _____

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

