Today's Date ___/___/_____

PATIENT HISTORY FORM

Name ____ **Date of Birth** ___/___/_____

Chief Complaint (What is the main reason for your visit today? Please describe in detail)

____

____

____

Medical History

Allergies:

- ❑ None Known
- ❑ Sulfa
- ❑ Penicillin
- ❑ Other Antibiotic or medication
  ____
  ____
- ❑ IVP/ CAT Scan Contrast
- ❑ Foods
  ____
  ____

Previous Medical Illnesses:

Have you ever had any of the following?

- ❑ Asthma
- ❑ Emphysema
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Heart attack or heart condition
- ❑ Increased blood pressure
- ❑ Blood Disorder
- ❑ Ulcer Disease
- ❑ Gallbladder disease
- ❑ Stroke
- ❑ Thyroid condition
- ❑ Kidney stones/ disease
- ❑ Any other condition not listed
- ❑ None of the above

Have you ever been hospitalized?

If so, when, where, and for what reason?

____

____

____

Have you ever had any operations?

If so, please list (dates if known).

____

____

____

Social History:

Do you smoke? ☐ Yes ☐ No

If Yes, how much? ___________________________

Any Illicit drug use? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If Yes, how much? ___________________________

Family History:

Has anyone in your family had any of the following diseases? Relation to you

- ☐ Diabetes ________________________
- ☐ Cancer ________________________
- ☐ Tuberculosis ________________________
- ☐ High Blood Pressure ________________________
- ☐ Kidney Disease ________________________
- ☐ Kidney Stones ________________________
- ☐ None of the above

For Women Only: Number of live births _____

Type of delivery:

Vaginal: _____________ Cesarean: ________________

When was your last pap smear? ___________________

For Men Only: Prostate Symptom Score

Over the past month or so, how often have you had the following: (0)=Never, (3)=half the time, (5)=always.

1. Felt as if bladder not empty after voiding 0 1 2 3 4 5
2. Need to urinate again within 2 hours 0 1 2 3 4 5
3. Stopped and started again while urinating 0 1 2 3 4 5
4. Found it difficult to postpone urination 0 1 2 3 4 5
5. Had a weak urinary stream 0 1 2 3 4 5
6. Had to push or strain to begin urination 0 1 2 3 4 5
7. Number of times you get up at night to urinate 0 1 2 3 4 5

Date of last PSA _________

Value of last PSA ________

Total Symptom Score ___________

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Patient Name: ____

Review of Systems: Do you now or have you had any problems related to the follow systems

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other ____________________________

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other ____________________________

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N

Other_____________________________

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other_____________________________

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other_____________________________

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other_____________________________

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other _____________________________

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other_____________________________

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other_____________________________

Ear/Nose/Throat/Mouth

Ear infections	Y	N
Sore throat	Y	N
Sinus Problems	Y	N

Other_____________________________

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other_____________________________

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of breath	Y	N

Other ____________________________

Hematologic/ Lymphatic

Swollen Glands	Y	N
Blood clotting problems	Y	N

Other_____________________________

Psychologic

Are you generally satisfied with life?	Y	N
Do you feel severely depressed?	Y	N
Have you ever considered suicide?	Y	N

Other_____________________________

Reviewed by: ____ **Date:** ______________________________