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)

_____

_____

_____

Height ____ feet___inches Weight_____

MEDICAL HISTORY

Allergies:

- ☐ None Known
- ☐ Sulfa
- ☐ Penicillin
- ☐ Other Antibiotic or medication

  _____

  _____
- ☐ IVP/CAT Scan Contrast
- ☐ Latex
- ☐ 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 operation?

If so, please list (dates if known)

_____

_____

_____

Social History:

Current smoker ☐ Former smoker ☐ Never ☐

Packs per day? _____ Years smoked? _____

Do you use marijuana? 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
☐ Hypertension	_____
☐ Hyperlipidemia	_____
☐ Coronary heart disease:	_____
☐ Diabetes	_____
☐ COPD	_____
☐ Thyroid disease	_____
☐ Kidney disease	_____
☐ Kidney Stones	_____
☐ Prostate cancer	_____
☐ Breast cancer	_____
☐ Other cancer	_____
☐ 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_____

Patient Name: _____

Review of Systems: Do you currently have any problems related to the following 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

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 _____		
Psychological		
Are you generally satisfied with life?	Y	N
Are you severely depressed?	Y	N
Have you ever considered suicide?	Y	N
Other _____		

Reviewed by: _____ Date: _____

Patient Name_____ DOB _____

Medication