

## Patient Name: \_\_\_\_\_ Health History Problems Reason for today's visit: \_\_\_\_\_ Onset (date): \_\_\_\_\_ **Allergies/Adverse Reactions** Drug/Allergen:\_\_\_\_\_ Reaction: \_\_\_\_\_ Date: \_\_\_\_\_ Drug/Allergen: \_\_\_\_\_ Reaction: \_\_\_\_\_ Date: \_\_\_\_\_ Drug/Allergen: \_\_\_\_\_ Date: \_\_\_\_\_ Family History Relation: Problem: Onset Age: Age of Death: Relation: Onset Age: Age of Death: Surgical History Procedure: \_\_\_\_\_\_ Surgery Date: \_\_\_\_\_ Procedure: \_\_\_\_\_ Surgery Date: \_\_\_\_\_ Procedure: \_\_\_\_\_ Surgery Date: \_\_\_\_\_ Vaccines Did you get the flu shot this year? If so, when?\_\_\_\_\_ Did you get the pneumonia vaccination this year? If so, when? \_\_\_\_\_ Social History (Please circle) Smoking Status: Never smoker Former smoker Current Smoker (every day) Current Smoker (some days) 1½ PPD 2 PPD Smoking – How much? None ¼ PPD ½ PPD 1 PPD 3+ PPD Chewing Tobacco: None 1/day 2-3/day 5+day

Tobacco - Years of Use: \_\_\_\_\_ Has smoked since age: \_\_\_\_\_ Alcohol Intake: Occasional Moderate Heavy Years of Use: None Do you use illicit drugs? Other: \_\_\_\_ None Marijuana Cocaine Heroin Ecstasy Inhalants Do you have an Advanced Directive? Do you have children? Yes No Yes No Hobbies/Activities: \_\_\_\_\_ Caffeine intake: \_\_\_\_\_ \_\_\_\_\_ Have you had a colonoscopy? If yes, date: \_\_\_\_\_\_ Occupation:

Medications you currently take and the dosage. Please include all medications prescribed by a physician and over the counter medications such as Tylenol, Motrin and all herbal medications.

Medication Name	Dosage



## Patient Name: \_\_\_\_\_

# Past Medical History – Please check all that apply

ADD/ADHD	Dementia/Alzheimer's Disease	Hyper/Hypothyroidism (over/underactive thyroid)	Prostate Cancer
Abnormal heart rhythm/Atrial fibrillation	Depression	Infertility	Prostatitis
Abscess	Diabetes	Interstitial Cystitis	Pulmonary Embolism
Anemia	Dialysis	Irritable Bowel Syndrome	Pulmonary Hypertension
Angina (chest pain)	Diverticulosis/Diverticulitis	Kidney Cancer	Renal Disease
Anxiety	Eating Disorder	Kidney Stone	Rheumatoid Arthritis
Arthritis	Elevated PSA	Lung Cancer	Schizophrenia
Asthma	Endometriosis	Lupus	Sciatica
BPH/Enlarged Prostate	Epilepsy (seizures)	MRSA Infection	Seasonal Allergies
Barrett's Esophagus	Erectile Dysfunction	Major Depressive Disorder	Sepsis
Bipolar Disorder	Fibroids	Migraine Headaches	Sexually Transmitted Disease (explain)
Bladder Cancer	Fibromyalgia	Multiple Sclerosis	Skin Cancer
Bladder Stones	GERD/Acid Reflux	Obesity	Skin Conditions
Brain Cancer	GI Bleed	Osteoporosis	Sleep Apnea
Breast Cancer	Gallstones	Ovarian Cancer	Stomach Cancer
COPD (Emphysema/chronic bronchitis)	Gastritis/Ulcers	Ovarian Cyst	Stroke/TIA
Cataract	Glaucoma	PTSD	Syncope (fainting)
Cervical Cancer or Cervical Dysplasia	Gout	Pancreatitis	Testicular Cancer
Chronic Pelvic Pain Syndrome	HIV Infection/AIDS	Parkinson's Disease	Tuberculosis/TB Exposure
Chronic Back Pain	Heart Attack	Pelvic Organ Prolapse	Ulcerative Colitis
Chronic Kidney Disease	Hemorrhoids	Pelvic Prolapse	Urinary Tract Infection (UTI)
Colorectal Cancer	Hepatitis	Peripheral Vascular Disease	Uterine Cancer
Congestive Heart Failure	Herniated Disc	Peyronie's Disease	Vaginal Cancer
Coronary Artery Disease	High Cholesterol	Peripheral Vascular Disease	Varicose Veins
Chron's Disease	Hydrocele	Pneumonia	Vertigo
DVT (Blood Clot)	Hypertension	Polycystic Ovary Syndrome	Vulvodynia

### Patient History – Can you think of anything else about you that your physician may need to know?



#### Patient Name: \_\_\_\_

**Review of Systems** - *Please circle any symptoms that you are currently experiencing:* 

FeverYesNoFatigueYesNoChillsYesNoWeight gain (lbs.)YesNoWeight loss (lbs.)YesNoEyesYesNoDry eyesYesNoEye irritationYesNoEars, Nose and ThroatHearing lossYesHearing lossYesNoSore throatYesNoDry mouthYesNoSore throatYesNoDry mouthYesNoCardiovascularCChest painYesNoPalpitationsYesNoLeg edemaYesNoShortness of breathYesNoNauseaYesNoShortness of appetiteYesNoLoss of appetiteYesNoLoss of appetiteYesNoLoss of appetiteYesNoDiarrheaYesNoBloody/black stoolYesNoHeartpurYesNoBowel leakageYesNoDifficulty/straining to urinateYesNoSoudden need to urinateYesNoSoudden need to urinateYesNoSloody/weak urinary systemYesNoSloody weak urinary systemYesNoSlood in urineYesNoSlood in urineYesNoSlood in urineYesNoSlood in urineYesNo <th>Constitutional</th> <th></th> <th></th>	Constitutional		
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Urinary frequencyYesNoBlood in urineYesNo		Yes	No
Blood in urine Yes No	•		-
			-
Waking from sleep to urinate Yes No			-
	waking from sleep to urinate	Yes	NO

Musculoskeletal		
Joint pain	Yes	No
Muscle pain	Yes	No
Back pain	Yes	No
Skin		
Rashes	Yes	No
Itching/dryness	Yes	No
Abnormal moles	Yes	No

MALE ONLY ổ :			
Testicular pain	Yes	No	
Erectile problems	Yes	No	
Painful intercourse	Yes	No	
Low sex drive	Yes	No	
Penile curvature	Yes	No	

FEMALE ONLY Q :			
Irregular periods	Yes	No	
Vaginal discharge	Yes	No	
Painful intercourse	Yes	No	
Low sex drive	Yes	No	
Breast pain/lump	Yes	No	
Date of last mammogram	n		

Date of last pap smear

<b>Neurologic</b> Dizziness Numbness Headaches Tremors	Yes Yes Yes Yes	No No No No
Psychiatric		
Stress	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Memory Loss	Yes	No
<b>Endocrine</b> Excessive thirst Heat/cold intolerance Hot flashes	Yes Yes Yes	No No No
Hematologic/Lymphatic:		
Swollen glands	Yes	No
Bruising easily	Yes	No
Excessive bleeding	Yes	No