PATIENT HISTORY FORM

Date: _____

Referring MD: _____ Primary Physician: _____

Last Name: _____ First Name:_____ Middle Initial:_____

Marital Status: _____ Date of Birth _____ Age: _____

Preferred Pharmacy: _____

PAST MEDICAL HISTORY (PLEASE CIRCLE):

Diabetes	High Blood Pressure		
Heart Attack	Stroke	Hepatits	Cancer (specify)_____
Kidney Stone	Lung Disease	Urinary Infection	Kidney Disease
Other: _____	_____	_____	_____

ALLERGIES (PLEASE CIRCLE): No Allergies

Pennicillin	Sulfa		
IVP dye	Demerol	Morphine	Betadine/Iodine
Latex	Tetracycline	Codeine	Cipro
Other: _____	_____	_____	_____

MEDICATIONS: **List all current medications, vitamins and supplements**

MEDICINE	DOSE/HOW OFTEN

PAST SURGICAL HISTORY: List all previous surgeries

SURGERY	DATE	LOCATION

FAMILY HISTORY: Do any family members have/had (circle)

Cancer	Yes No	Who:	_____
If yes, specify:	_____		
Stroke	Yes No	Who:	_____
Kidney Disease	Yes No	Who:	_____
Prostate Cancer	Yes No	Who:	_____
Diabetes	Yes No	Who:	_____
Heart Disease	Yes No	Who:	_____
Kidney Stones	Yes No	Who:	_____
Other:	_____	Who:	_____
Other:	_____	Who:	_____

SOCIAL HISTORY:

Occupation_____

Do you smoke? No Yes How much? ____

Do you drink alcohol? No Yes How much? ____

How long have you smoked?_____

Have you ever smoked? (circle one) No Yes

If yes how much: ____ Day

When did you quit? _____

Do you have a decreased interest in sex which bothers you: No Yes

PLEASE TURN OVER & COMPLETE OTHER SIDE

APPLY PATIENT LABEL HERE

MR

REVIEW OF SYSTEMS:

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Headache	Yes	No
Other: _____		

Eyes

Blurred vision	Yes	No
Double-vision	Yes	No
Glaucoma	Yes	No
Other: _____		

Ear/Nose/Throat/Mouth

Ear infection	Yes	No
Sore throat	Yes	No
Sinus problems	Yes	No
Other: _____		

Cardiovascular

Heart trouble	Yes	No
Chest pain	Yes	No
Ankle swelling	Yes	No
High blood pressure	Yes	No
Other: _____		

Respiratory

Wheezing	Yes	No
Frequent cough	Yes	No
Shortness of breath	Yes	No
Other: _____		

Gastrointestinal

Fecal Incontinence/Leakage	Yes	No
Abdominal pain	Yes	No
Nausea/vomiting	Yes	No
Indigestion/heart burn	Yes	No

Genitourinary

Urinary retention	Yes	No
Painful urination	Yes	No
Urinary frequency	Yes	No
Sexual concerns	Yes	No
Loss of interest in sex	Yes	No
Urine leakage/Incontinence	Yes	No

Integumentary

Skin rash	Yes	No
Boils	Yes	No
Persistent itch	Yes	No
Cosmetic skin concerns	Yes	No
Other: _____		

Neurological

Tremors	Yes	No
Dizzy spells	Yes	No
Numbness/tingling	Yes	No
Other: _____		

Musculoskeletal

Joint pain	Yes	No
Neck pain	Yes	No
Back pain	Yes	No
Other: _____		

Endocrine

Excessive thirst	Yes	No
Too hot/too cold	Yes	No
Tired/sluggish	Yes	No
Other: _____		

Psychological

Are you generally satisfied with your life?	Yes	No
Do you feel severely depressed?	Yes	No
Have you considered suicide?	Yes	No

Hematologic/Lymphatic

Bleeding problems	Yes	No
Swollen glands	Yes	No
Blood clotting	Yes	No
Other: _____		

Allergic/Immunologic

Hay fever	Yes	No
Drug/food allergies	Yes	No
Other: _____		

Is there anything else you need to discuss with your doctor?

Nurse use only: BP ____ / ____ Pulse:_____ Temp:_____ Weight:_____Height:_____

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