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**PATIENT HISTORY FORM**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST OF REASON(S) FOR TODAY’S VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY** - CHRONIC MEDICAL CONDITIONS (CHECK ALL THE APPLY):

|  |  |  |  |
| --- | --- | --- | --- |
| □ BLEEDING PROBLEMS | □ KIDNEY DISEASE | □ HYPERTENSION | □ OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ HEART DISEASE | □ KIDNEY STONES | □ DIABETES | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| PRIOR SURGERIES | □ HYSTERECTOMY \_\_\_\_\_\_\_\_\_\_\_\_\_ | □ VASECTOMY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (INCLUDING DATES): | □ LITHOTRIPSY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ OTHER (PLEASE SPECIFY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES TO IODINE/SHELLFISH: □ YES □ NO

**MEDICATION HISTORY** – PLEASE LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER THE COUNTER.

□ **NONE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NAME OF DRUG** | **MG DOSE** | **# TIMES PER DAY** | **NAME OF DRUG** | **MG DOSE** | | **# TIMES PER DAY** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FAMILY HISTORY** - PLEASE SPECIFY WHICH FAMILY MEMBER.

KIDNEY STONES □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CERVICAL CANCER □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

KIDNEY CANCER □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HYPERTENSION □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLADDER CANCER □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIABETES □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UTERINE CANCER □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEART DISEASE □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROSTATE CANCER □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHER □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BREAST CANCER □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OVARIAN CANCER □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY** – (CHECK ALL THAT APPLY.)

|  |  |  |  |
| --- | --- | --- | --- |
| TOBACCO USE: | □ NON SMOKER | □ SMOKER – \_\_\_\_ PACKS/DAY \_\_\_\_ YEARS | □ PREVIOUS SMOKER – QUIT \_\_\_\_\_\_\_ |
| ALCOHOL USE: | □ NON DRINKER | □ DRINKER □ SOCIAL |  |
| CAFFEINE USE: | □ YES | □ NO |  |