**PATIENT HISTORY FORM** DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

PRIMARY DOCTOR & PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY NAME & PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING DOCTOR & PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

CHRONIC MEDICAL CONDITIONS (CHECK ALL THE APPLY):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| □ BLEEDING PROBLEMS | | □ KIDNEY DISEASE | ­­­­­­­­­­­­­­□ CARDIAC STENT PLACEMENT | | |
| □ HEART DISEASE  □ HIGH BLOOD PRESSURE  □ PERIPHERAL VASCULAR DISEASE | | □ KIDNEY STONES  □ OPEN HEART SUGERY  □ PACEMAKER | □ CANCER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ DEFIBRILLATOR □ DIABETES |  | |
| PRIOR SURGERIES: \***INCLUDING DATES** | | □ KIDNEY STONE SURGERY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | | □ COLONOSCOPY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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

ALLERGIES TO IODINE/SHELLFISH: □ YES □ NO □ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION HISTORY** –PLEASE LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER THE COUNTER): □ NONE

ARE YOU TAKING ANY BLOOD THINNERS? □ YES □ NO

DO YOU TAKE: □ ASPRIN □ COUMADIN □ WARFARIN □ ELIQUIS □ XARELTO □ PRADAXA □ PLAVIX □ AGGRENOX

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

**FAMILY HISTORY**

FAMILY HISTORY OF: (PLEASE SPECIFY 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DID YOU GET A FLU SHOT THIS YEAR? DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DID YOU GET A PNEUMOCOCCAL VACCINE THIS YEAR? DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| TOBACCO USE: | □ NON SMOKER | □ SMOKER \_\_\_\_\_ PACKS/DAY \_\_\_\_ YEARS | □ PREVIOUS SMOKER – QUIT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ALCOHOL USE: | □ NON DRINKER | □ DRINKER □ SOCIAL |  |
| CAFFEINE USE: | □ YES | HOW MANY CAFFEINE DRINKS PER DAY? 0 1 2 3 4 | |

HEIGHT \_\_\_\_\_\_\_\_\_ FEET\_\_\_\_\_\_\_\_\_ INCHES WEIGHT \_\_\_\_\_\_\_\_\_\_\_\_ LB

**UROLOGY CONT’D**

NIGHTTIME URINATION □ YES □ NO

DIFFICULTY STARTING URINARY STREAM □ YES □ NO

LEAKAGE OR DRIBBLING □ YES □ NO

REDUCED FLOW □ YES □ NO

BLOOD IN URINE □ YES □ NO

STRAINING TO URINATE □ YES □ NO

**MUSCULOSKELETAL**

BACK PAIN □ YES □NO

MUSCLE WEAKNESS □ YES □ NO

JOINT SWELLING, STIFFNESS, PAIN □ YES □ NO

**GYNECOLOGIC**

POST MENOPAUSAL □ YES □ NO

CURRENTLY ON HORMONE REPLACEMENT? □ YES □ NO

VAGINAL DRYNESS □ YES □ NO

PELVIC PAIN □ YES □ NO

VAGINAL DISCHARGE □ YES □ NO

VAGINAL ITCHING □ YES □ NO

**MALE REPRODUCTIVE**

DIFFICULTY WITH ERECTION □ YES □ NO

DIFFICULTY WITH EJACULATION □ YES □ NO

DIMINISHED SEXUAL DRIVE □ YES □ NO

**HEMATOLOGIC / LYMPHATIC**

BRUISES EASILY □ YES □ NO

SWOLLEN LYMPH NODES □ YES □ NO

BLOOD CLOTTING PROBLEM □ YES □ NO

LOSS OF APPETITE □ YES □ NO

**DERMATOLOGY**

ECZEMA □ YES □ NO

DRY OR SENSITIVE SKIN □ YES □ NO

SKIN CANCER □ YES □ NO

**NEUROLOGY**

INSOMNIA □ YES □ NO

DIZZINESS □ YES □ NO

WEAKNESS □ YES □ NO

HEADACHE □ YES □ NO

NUMBNESS / TINGLING □ YES □ NO

SEIZURES / CONVULSIONS □ YES □ NO

LEG WEAKNESS □ YES □ NO

ANXIETY □ YES □ NO

DEPRESSION □ YES □ NO

OTHER NEUROLOGIC CONDITIONS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ENDOCRINOLOGY**

FATIGUE □ YES □ NO

EXCESSIVE THIRST □ YES □ NO

EXCESSIVE URINATION □ YES □ NO

COLD INTOLERANCE □ YES □ NO

HOT FLASHES □ YES □ NO

CHILLS □ YES □ NO

WEIGHT GAIN □ YES □ NO

WEIGHT LOSS □ YES □ NO

FEVER □ YES □ NO

WEAKNESS □ YES □ NO

**OPHTHALMOLOGY**

BLURRING OF VISION □ YES □ NO

LOSS OF VISION □ YES □ NO

**ENT**

DIFFICULTY SWALLOWING □ YES □ NO

SORE THROAT □ YES □ NO

COUGH □ YES □ NO

SINUS PROBLEMS □ YES □ NO

HEARING LOSS / DIFFICULTY HEARING □ YES □ NO

NOSE BLEEDS □ YES □ NO

TINNITIS (RINGING IN EAR) □ YES □ NO

**CARDIOLOGY**

SWELLING OF ANKLES □ YES □ NO

SHORTNESS OF BREATH □ YES □ NO

CHEST PAIN WITH EXERTION □ YES □ NO

DIZZINESS □ YES □ NO

IRREGULAR HEARTBEAT □ YES □ NO

PALPITATIONS □ YES □ NO

**RESPIRATORY**

SHORTNESS OF BREATH □ YES □ NO

COUGH □ YES □ NO

**GASTROENTEROLOGY**

ABDOMINAL PAIN □ YES □ NO

CONSTIPATION □ YES □ NO

NAUSEA / VOMITING □ YES □ NO

HEARTBURN / INDIGESTION □ YES □ NO

DIARRHEA □ YES □ NO

BLOOD IN STOOL □ YES □ NO

**UROLOGY**

FREQUENT URINATION □ YES □ NO

URGENT NEED TO URINATE □ YES □ NO

PAIN WITH URINATION □ YES □ NO