PATIENT HISTORY FORM

DATE _____

LAST NAME_____ FIRST NAME_____ DATE OF BIRTH ____/____/____

CHIEF COMPLAINT

Patient signature _____

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

_____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem

_____

_____

On a scale of 1-10, with 10 being the most severe,
Circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

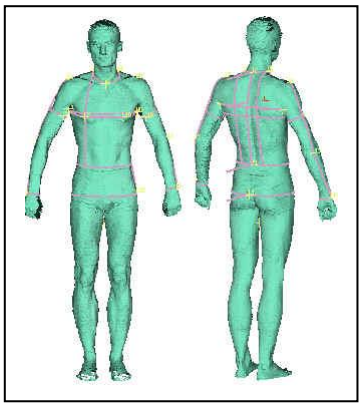
When did you first notice the problem?

_____

Does anything help or make the problem worse??

_____

Mark location ⇒



Recent x-rays
Or Blood tests?
Which ones_____

Past Medical and Social History

List all past and current illnesses for which you have been or are being treated:

_____

_____

_____

_____

_____

_____

_____

_____

List all prior surgeries Date

_____

_____

_____

_____

_____

Cigarettes (now/past)? Y N
How much_____
Alcohol (now/past)? Y N
How much_____
Caffeine? Y N
How much_____
Recreational drug use? Y N
Sexually active? Y N
Exercise regularly Y N
Marital Status:
Single Married Divorced Widowed
Occupation_____

Family history of medical illnesss:

_____

_____

_____

ALLERGIES to Medications:

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT HISTORY FORM

DATE _____

Male Patients

Describe your voiding over the past month. Circle how often have you had the following symptoms.

Do you have any concerns or questions regarding erectile dysfunction (ED)? Y N

PROSTATE SYMPTOM SCORE	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Incomplete Emptying – having the sensation of not emptying completely	0	1	2	3	4	5
Frequency – having to urinate again less than 2 hours after you finished urinating	0	1	2	3	4	5
Intermittency – having to stop and start again several times while urinating	0	1	2	3	4	5
Urgency – having difficulty postponing urination	0	1	2	3	4	5
Weak Stream – noticed a weak urinary stream	0	1	2	3	4	5
Straining – having to push or strain to begin urination	0	1	2	3	4	5

Sleeping- How many times do you typically get up to urinate at night? _____

Total Score: _____

Explain_____

_____

Female Patients

Problems with urinary control?	Y	N	For how long_____	Number of children by
Do you leak with cough or activity?	Y	N	How much_____	vaginal delivery _____
Do you have to wear any protective pads?	Y	N	How many per day_____	
Do you urinate frequently?	Y	N	How often_____	C-Section_____
If you have an urge to urinate, can you hold it?	Y	N	Any accidents_____	

Explain_____

_____

Review of Systems

Do you now have any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms			**Gastrointestinal**			**Ear/Nose/Throat**		
Fever	Y	N	Abdominal Pain	Y	N	Ear infection	Y	N
Chills	Y	N	Nausea/vomiting	Y	N	Sore throat	Y	N
Weight loss	Y	N	Indigestion/heartburn	Y	N	Sinus problems	Y	N
			Cardiovascular			**Respiratory**		
Eyes			Chest pain	Y	N	Wheezing	Y	N
Blurred vision	Y	N	High blood pressure	Y	N	Frequent cough	Y	N
Double vision	Y	N	**Integumentary**			Shortness of breath	Y	N
			Skin rash	Y	N	**Genitourinary**		
Neurological			Boils	Y	N	Painful urination	Y	N
Tremors	Y	N	Persistent itch	Y	N	Urinary frequency	Y	N
Dizzy spells	Y	N	**Musculoskeletal**			**Hematologic/Lymphatic**		
Numbness/tingling	Y	N	Joint pain	Y	N	Swollen glands	Y	N
Endocrine			Back pain	Y	N	Blood clotting prob.	Y	N
Excessive thirst	Y	N	**Allergic/Immunologic**			**Psychologic**		
Too hot/cold	Y	N	Hay fever	Y	N	Depression	Y	N
Tired/sluggish	Y	N	Food allergies	Y	N			

Explain_____

_____

_____