

AMP PATIENT HISTORY FORM

Today's Date: _____ Date of Last Physical Exam _____

Last Name: _____ First: _____ Middle: _____

Social Security No: _____ Date of Birth: _____

Referring Physician: _____

History of Present Illness

Please answer the following questions

CHIEF COMPLAINT

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

Location of the problem
Bladder Urine Prostate Kidney
Other _____

How long does the problem last?
30 minutes 1 hour It is always there
Other _____

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

Is the problem constant or variable?
Dull then Sharp Very sharp then leaves Always there
Other _____

Does the problem interfere with your
normal functions?
Yes No If yes, please explain

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other _____

PHYSICIAN USE ONLY: (Comments/Notes)

Name _____ Appointment date: _____
(Last) (First) (MI)

Past Medical, Family & Social History

List any personal past illnesses: Date:
(Example: Diabetes, heart disease, etc.)

List any surgeries: Date:

Medications with dose you are on: Aspirin Y N

Allergies to medications: _____

List serious illnesses in your immediate family:
(Example: Prostate cancer, kidney stones, etc.)

Habits:

Tobacco Y N Quit When? _____
If Yes: How many packs? _____ Years _____

Alcohol Y N If yes, how much? _____

Caffeinated Beverages? Y N Ounces per day _____

Social:

Occupation: _____

Marital Status: S M D W

Name _____ Appointment date: _____
 (Last) (First) (MI)

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**.
 Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Weak stream	Y	N
Daytime urinary frequency	Y	N
Nighttime urinary frequency	Y	N
Blood in urine	Y	N
Erectile dysfunction	Y	N
Urine leakage	Y	N
Other _____		

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other _____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other _____		

PHYSICIAN USE ONLY: (Comments/Notes)

 SIGNATURE OF PHYSICIAN
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