

# PATIENT HISTORY FORM

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Today's Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS

Chief Complaint												
<b>What is the main reason for your visit today?</b> (Describe in detail)												
Location of the problem (circle selection)					How long does the problem last? (circle selection)							
Bladder	Urine	Prostate	Kidney		30 minutes	1 hour	It is always there					
Other:					Other:							
Problem Severity (circle selection) Scale of 1 to 10, 10 being most severe					Is the problem constant or variable? (circle selection)							
1	2	3	4	5	6	7	8	9	10	Dull then Sharp	Very sharp then leaves	Always there
										Other:		
When did you first notice the problem? (circle selection)					Does the problem interfere with your normal functions? (circle selection)							
2 days ago		2 weeks ago		1 month ago			Yes		No			
Other:					If yes, please explain:							

**COMMENTS/NOTES** (Physician Use Only):

**Name** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Last First Middle **Date of Birth:** \_\_\_\_\_

**PAST MEDICAL, FAMILY & SOCIAL HISTORY**

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<p><b>Identify past personal illnesses:</b> (circle selections + date)</p> <p>Cancer                    Y    N    _____</p> <p>High Blood Pressure    Y    N    _____</p> <p>Diabetes                    Y    N    _____</p> <p>Lung Disease            Y    N    _____</p> <p>High Cholesterol        Y    N    _____</p> <p>Heart Disease            Y    N    _____</p> <p>Thyroid Disease         Y    N    _____</p> <p>Other: _____</p>	<p><b>List any Medical Problems/Hospitalizations:</b></p>
<p><b>List any surgeries with date:</b></p>     <p>Defibrillator/Pacemaker            Y            N</p>	<p><b>Medications with dosage:</b></p>     <p>Aspirin                                    Y            N</p>
<p><b>List serious illnesses in your immediate family:</b>        (Example: Prostate cancer, kidney stones, etc.)</p>	<p><b>Allergies:</b> (Medications/Others)</p>
<p><b>Social History:</b></p> <p>Occupation: _____</p> <p>Marital Status:    <input type="checkbox"/> Single            <input type="checkbox"/> Married                                 <input type="checkbox"/> Divorced            <input type="checkbox"/> Widowed</p>	<p><b>Habits:</b></p> <p>Tobacco            Y    N    Quit When? _____</p> <p>Cigarettes        Y    N    Years: _____ Packs Per Day: _____</p> <p>Cigars             Y    N    Years: _____ # Per Day: _____</p> <p>Pipe                Y    N    Years: _____ Times Per Day: _____</p> <p>Alcohol            Y    N    If yes, how much? _____</p> <p>Caffeinated Beverages?    Y    N    Ounces per day? _____</p>
<p><b>Ob/Gyn History</b> (female patients only):</p> <p>Pregnancies:        Y    N    How many? _____</p> <p>Live births:         Y    N    How many? _____</p> <p>Sexually active:    Y    N    _____</p> <p>Last menstrual period: _____</p>	

Name

Last

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Date:

Date of Birth:

**REVIEW OF SYSTEMS**

(circle selections)

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<b>Constitutional Symptoms</b>			<b>Musculoskeletal</b>		
Fever or chills	Y	N	Joint Pain	Y	N
Weight loss	Y	N	Bone Pain	Y	N
Other:			Other:		
<b>Eyes</b>			<b>Skin</b>		
Blurry vision	Y	N	Itching	Y	N
Double vision	Y	N	Rash	Y	N
Other:			Other:		
<b>Cardiovascular</b>			<b>Neurological</b>		
Chest pain	Y	N	Numbness	Y	N
Palpitations	Y	N	Tingling	Y	N
Other:			Other:		
<b>Respiratory</b>			<b>Hematologic/Lymphatic</b>		
Shortness of breath	Y	N	Blood clotting disorder	Y	N
Wheezing	Y	N	Bruising	Y	N
Other:			Other:		
<b>Gastrointestinal</b>			<b>Genitourinary</b>		
Nausea/vomiting	Y	N	Blood in urine	Y	N
Heartburn/indigestion	Y	N	Daytime urinary frequency	Y	N
Other:			Nighttime urinary frequency	Y	N
			Erectile dysfunction	Y	N
			Kidney disorder	Y	N
			Sexually transmitted diseases	Y	N
			Urine leakage	Y	N
			Urine retention	Y	N
			Weak stream	Y	N
			Other:		

**COMMENTS/NOTES** (Physician Use Only):

SIGNATURE OF PHYSICIAN