

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_ MED REC #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_ HEIGHT: \_\_\_ FT \_\_\_ IN WEIGHT: \_\_\_\_\_ LBS

Referring Physician: \_\_\_\_\_ Referring Physician's Phone #: \_\_\_\_\_ Referring Physician's Address: \_\_\_\_\_

Primary Care Physician (if Different) \_\_\_\_\_ Phone #: \_\_\_\_\_

Race:  White  Black  Hispanic / Latin  Asian Other: \_\_\_\_\_ Sex:  Female  Male

Marital/Family Status:  Single  Married  Divorced  Widowed Previously widowed?  Yes  No Previous divorce?  Yes  No

Do you have children?  Yes  No If so, number: \_\_\_\_\_

Reason for your visit today: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Other Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

### Medical History

	Yes	No		Yes	No		Yes	No
Angina (chest pain related to heart disease) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Gout . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Emboli (Blood Clot in Lung) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait/Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis (Hardening of the Arteries) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Stroke . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Arthritic Joints . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	If yes, do you take antibiotics for dental procedures? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Asthma . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
COPD . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Use of Coumadin . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Depression . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	HIV . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Valvular Heart Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Deep Vein Thrombosis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid (Low Thyroid) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other:</b>		
Elevated Cholesterol . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker Placement . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____		
			Parkinson's Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____		

### Medications: (continue on reverse side if more space is needed)

### Family History

Name	Strength	Frequency	FAMILY HISTORY of kidney stones? <input type="checkbox"/> Yes <input type="checkbox"/> No
Daily use of aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>FEMALES ONLY</b>
_____			# pregnancies _____ # children _____
_____			Date of Last Menstrual Period? _____
_____			Date of Last PAP Smear? _____
_____			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
_____			<b>MALES ONLY</b>
_____			History of Prostate Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
_____			Family History of Prostate Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____			Date of your last prostate exam? _____
_____			Date of your last PSA test? _____

### Surgical History: (continue on reverse side if more space is needed)

### Social History

Year	Operation	Hospital	Do you or have you smoked Cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit (Year _____) # packs per day? _____
_____			Do you or have you used alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit (Year _____) # drinks per week? _____
_____			Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit (Year _____)
_____			Coffee Cups Per Day 0 1 2 3 4+
_____			Tea Cups Per Day 0 1 2 3 4+
_____			Carbonated Drinks Cans Per Day 0 1 2 3 4+
_____			Water Cups Per Day 0 1 2 3 4+
_____			Exercise Activity: _____
_____			Occupation: _____

<b>Over the past month, how often have you:</b>	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
1.had a sensation of not emptying your bladder completely after urinating?	0	1	2	3	4	5
2.had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3.found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4.found it difficult to postpone urination?	0	1	2	3	4	5
5.had a weak urinary stream?	0	1	2	3	4	5
6.had to push or strain to begin urination?	0	1	2	3	4	5
7.most typically gotten up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	(number of times) 3	4	5
Total score _____						

**PATIENT REVIEW OF SYSTEMS:** Please mark all yes or no

<b>Constitutional--<input type="checkbox"/>Neg</b> Yes No chills <input type="radio"/> <input type="radio"/> fever <input type="radio"/> <input type="radio"/>	<b>Respiratory--<input type="checkbox"/>Neg</b> Yes No dyspnea <input type="radio"/> <input type="radio"/> (shortness of breath)	<b>Gastrointestinal--<input type="checkbox"/>Neg</b> Yes No diarrhea <input type="radio"/> <input type="radio"/>	<b>Metabolic/Endocrine--<input type="checkbox"/>Neg</b> Yes No goiter <input type="radio"/> <input type="radio"/>	<b>Musculoskeletal--<input type="checkbox"/>Neg</b> Yes No back pain <input type="radio"/> <input type="radio"/>
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<b>Heent---<input type="checkbox"/>Neg</b> Yes No double vision <input type="radio"/> <input type="radio"/>	<b>Cardiovascular--<input type="checkbox"/>Neg</b> Yes No chest pain <input type="radio"/> <input type="radio"/>	<b>Integumentary--<input type="checkbox"/>Neg</b> Yes No rash <input type="radio"/> <input type="radio"/>	<b>Neurological--<input type="checkbox"/>Neg</b> Yes No syncope/fainting <input type="radio"/> <input type="radio"/>	<b>Hema/Lymphatic--<input type="checkbox"/>Neg</b> Yes No easy bleeding <input type="radio"/> <input type="radio"/> petechiae/easy <input type="radio"/> <input type="radio"/> bruising
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**Additional Information / Medications / Surgical History**

<b>Psychiatric--<input type="checkbox"/>Neg</b> Yes No anxiety <input type="radio"/> <input type="radio"/>
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**11 System ROS**  
 All Negative

**FOR DOCTORS ONLY:**

CHIEF COMPLAINT

PRESENT ILLNESS

PHYSICAL EXAM

PROCEDURES

LAB

OUTSIDE RECORDS

ASSESSMENT

PLAN