

PATIENT NAME: _____ **DATE:** ___/___/___ **MED REC #:** _____
DATE OF BIRTH: ___/___/___ **AGE:** _____ **HEIGHT:** ___ FT ___ IN **WEIGHT:** _____ LBS
 Name of Referring Physician: _____ Referring Physician's Phone #: _____
 Referring Physician's Address: _____
 Primary Care Physician (if Different) _____ Phone #: _____
 Race: White Black Hispanic/Latino Asian Other: _____ Sex: Female Male
Reason for your visit today: _____

Pharmacy Name: _____ **Address:** _____ **City:** _____ **Zip:** _____
Pharmacy Phone #: _____ **Pharmacy Fax #:** _____

Drug Allergies: _____
 Other Allergies: _____

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely:

Name of Drug or Supplement:	Strength (mg):	How often (# of times per day)

MEDICAL HISTORY: Please check any of the following conditions which **YOU** have had or presently have:

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic UTIs | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Neurologic disease | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Valvular heart disease |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Depression | <input type="checkbox"/> Inflammatory bowel | <input type="checkbox"/> Peptic Ulcer disease | |
| <input type="checkbox"/> Cancer-
Type: _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Peripheral vascular disease | |
| | <input type="checkbox"/> Diverticular disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Renal/Kidney disease | |
| | <input type="checkbox"/> GERD | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Rheumatoid arthritis | |
| <input type="checkbox"/> CVA (Stroke) | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure disorder | |

♀ **FEMALES ONLY:** **Date of last Menstrual Period:** ___/___/___ **Date of last PAP Smear:** ___/___/___ ♀

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure

	Yr		Yr		Yr	♀ Females Only		♂ Males Only	
<input type="checkbox"/> Adrenalectmy		<input type="checkbox"/> Cystoscopy		<input type="checkbox"/> Liver biopsy			Yr		Yr
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> ESWL		<input type="checkbox"/> Kidney removed		<input type="checkbox"/> Bladdr suspnsn		<input type="checkbox"/> Brachytherapy	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Gastic bypass		<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Breast biopsy		<input type="checkbox"/> Circumcision	
<input type="checkbox"/> Bladder Augumentn		<input type="checkbox"/> Hernia repair		<input type="checkbox"/> Perc stone removal		<input type="checkbox"/> C-Section		<input type="checkbox"/> Hernia Repair	
<input type="checkbox"/> CABG		Type: _____		<input type="checkbox"/> Kidney stone removal		<input type="checkbox"/> Abd Hyst		<input type="checkbox"/> Hydrocoelectomy	
<input type="checkbox"/> Gall Bladder				<input type="checkbox"/> Ureteral Stents Plcd		<input type="checkbox"/> Mastectomy		<input type="checkbox"/> Laser of Prostate	
<input type="checkbox"/> Colectomy		<input type="checkbox"/> Hip replacement		Other:		<input type="checkbox"/> Vaginal Sling		<input type="checkbox"/> Orchiectomy	
<input type="checkbox"/> Colon surgery		<input type="checkbox"/> Knee replacemnt		<input type="checkbox"/>		<input type="checkbox"/> TAH / BSO		<input type="checkbox"/> Penile Prosthesis	
<input type="checkbox"/> Coronary stent		<input type="checkbox"/> Laparoscopy		<input type="checkbox"/>		<input type="checkbox"/> Tubal ligation		<input type="checkbox"/> Prostate Biopsy	
<input type="checkbox"/> Bladder removal		<input type="checkbox"/> Lithotripsy		<input type="checkbox"/>		<input type="checkbox"/> Vaginal Hyst		<input type="checkbox"/> Prostatectomy	
								<input type="checkbox"/> Spermatocelectomy	
								<input type="checkbox"/> TURP	
								<input type="checkbox"/> Varicocele ligation	
								<input type="checkbox"/> Vasectomy	

Patient Name: _____

Med Rec-#: _____

CHRONIC PROBLEMS LIST: Please list any **chronic** health problems you have

Problem: _____	Date of onset: _____	Treatment: _____
Problem: _____	Date of onset: _____	Treatment: _____
Problem: _____	Date of onset: _____	Treatment: _____
Problem: _____	Date of onset: _____	Treatment: _____

FAMILY HISTORY: Please check any of the following conditions that apply to your family members and list their relation to you:

Diagnosis:	Yes	No	Relationship:	Diagnosis:	Yes	No	Relationship
Blood disease				High Cholesterol			
BPH				High Blood Pressure			
Cancer				Inflammatory bowel disease			
Type:				Migraines			
CVA / Stroke				Renal failure			
Coronary artery disease				Seizure disorder			
Diabetes				Thyroid disorder			
Eczema				Urinary tract infections			
Gout				Kidney stones			
Hearing Impairment				Other:			
Other:							

Marital/Family Status:

Current Status: Single Married Divorced Widowed Previously widowed? Yes No Previous divorce? Yes No
 Do you have children? Yes No If so, number: _____

LIFESTYLE:

Occupation: _____
 Exercise? Yes No If yes, Type: _____ Frequency: _____ per _____ Hours per week: _____

TOBACCO:

Uses tobacco? Yes No Former Tobacco type: _____ Units per day: _____ Number of years: _____
 If former user: Units per day: _____ Number of years: _____ Year quit: _____

CAFFEINE: Yes No

ALCOHOL: Yes No formerly Year quit: _____

Type: _____, _____ Type: _____ Frequency: _____
 Amount daily: _____ Amount: _____ per _____ Last drink: _____

REVIEW OF SYSTEMS: Please mark all yes or no

Constitutional--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> chills <input type="radio"/> <input type="radio"/> fever	Respiratory--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> dyspnea (shortness of breath)	Gastrointestinal--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> diarrhea	Metabolic/Endocrine---<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> goiter	Musculoskeletal--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> back pain
Heent---<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> double vision	Cardiovascular--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> chest pain	Integumentary--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> rash	Neurological--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> dizziness	Hema/Lymphatic--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> easy bleeding <input type="radio"/> <input type="radio"/> petechiae/easy bruising
		Psychiatric--<input type="checkbox"/>Neg No Yes <input type="radio"/> <input type="radio"/> anxiety		

11 System ROS

All Negative