

Acct# _____

MD _____

PATIENT HISTORY FORM (Please fill out both sides)

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Family or Referring Doctor: _____

Pharmacy _____ Pharmacy # _____ Appointment Date: _____

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT (What is the main reason for your visit today?) _____

Date of onset, _____ List location (left or right) _____

Any Test? What type? _____

Blood in Urine? Y / N
 Color of Urine? Bright Red ____, Pink ____,
 Dark Red ____, Clear ____, Microscopic ____
 Clots in Urine? Y / N
 Frequent Urination? Y / N
 How Often? Every _____ hours
 Nocturia? (Urinating at night) Y / N
 How Often? _____ times a night

Slow or weak stream? Y / N
 Burning with Urination? Y / N
 Leaking of Urine? Y / N All the time? Y / N
 With exercise ____, With Cough ____
 Pain with Intercourse? Y / N
 Problems with Erections? Y / N
 Have you had this problem before? Y / N
 When? _____

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY

List all serious illnesses including hospitalizations:

None _____

List all serious illnesses in your immediate family:

None _____
 Mother: Living __ Died __ Age __ Died of _____
 Father : Living __ Died __ Age __ Died of _____

Have you ever been diagnosed with:

(Circle yes (Y) or no (N); may place long circle around no answers if appropriate)

- | | | | | | |
|---|---|--------------------------|---|---|-------------------|
| Y | N | Urinary Tract Infections | Y | N | Cancer Type |
| Y | N | Prostate Problems | Y | N | Kidney Stones |
| Y | N | Heart Attack | Y | N | Venereal Disease |
| Y | N | Heart Disease | Y | N | Heart Murmur |
| Y | N | Stroke | Y | N | Vascular Disease |
| Y | N | Blood Clots | Y | N | Diabetes |
| Y | N | High Blood Pressure | Y | N | Epilepsy/Seizures |
| Y | N | Asthma | Y | N | Emphysema |
| Y | N | Pneumonia | Y | N | Ulcers |

Occupation (Specify) _____

Marital Status: _____ Years? _____

How many children? _____

Females: Are you pregnant? Y/N How many pregnancies? _____

Vaginal __ C-Section __ Date of last menstrual period: _____

Do you smoke? Y / N

Have you smoked in the past? Y / N

How much? _____ How long? _____

When did you Quit? _____

Do you drink? Alcohol Y / N,

How much? Beer _____ Wine _____ Liquor _____

Coffee Y / N, How much? _____

Tea Y / N, How much? _____

Soda Y / N, How much? _____ What kind? _____

Explain any "yes" answers in space provided on back

List all surgeries: _____

None _____

Current medications (including over-the-counter and herbal medications):

None _____

List all drug allergies (along with reactions):

Acct# _____

MD _____

None _____

REVIEW OF SYMPTOMS

Are you currently having problems with the following? (Circle yes (Y) or no (N); may place long circle around no answers if appropriate)

Constitution:	Y	N	Fever	Gastrointestinal:	Y	N	Abdominal pain
	Y	N	Chills		Y	N	Nausea / vomiting
	Y	N	Weight loss		Y	N	Indigestion / heartburn
	Y	N	Loss of appetite/Changes		Y	N	Constipation
	Y	N	Night sweats		Y	N	Blood in stool
	Y	N	Headaches		Y	N	Diarrhea
Eyes:	Y	N	Blurred vision	Integumentary	Y	N	Skin Rash
	Y	N	Double vision		Y	N	Persistent Itch
	Y	N	Eye pain	Musculoskeletal:	Y	N	Joint pain
Allergic/ Immunologic	Y	N	Drug Allergies		Y	N	Back pain
	Y	N	Seasonal Allergies		Y	N	Neck pain / Stiffness
Neurological:	Y	N	Tremors	Ear/Nose/Throat/ Mouth	Y	N	Earache
	Y	N	Seizures		Y	N	Sore Throat
	Y	N	Dizziness Spells		Y	N	Sinus Problems
	Y	N	Numbness / tingling	Respiratory:	Y	N	Shortness of breath
Endocrine:	Y	N	Excessive thirst		Y	N	Wheezing
	Y	N	Fatigue / sluggishness		Y	N	Chronic cough
	Y	N	Hot / cold feeling	Hematologic	Y	N	Easy Bruising
Cardiovascular:	Y	N	Chest pain		Y	N	Bleeding Problems
	Y	N	High blood pressure	Psychologic	Y	N	Depression
	Y	N	Ankle swelling		Y	N	Anxiety

ALL OTHER REVIEW OF SYMPTOMS NEGATIVE

Explain any "Yes" answer in this space: _____

Physician Comments

