

Patient History Form



Do not fill out this form unless instructed by the office. Staff will call for this information.

Acct# _____ MD _____

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: List all serious illnesses in your immediate family:

☐ None _____

Have you ever been diagnosed with:

Circle yes (Y) or no (N)

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

☐ None _____

Mother: Living _____ Died _____ Age _____ Died of _____

Father: Living _____ Died _____ Age _____ Died of _____

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? _____

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? _____

List all surgeries:

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

Acct# _____

MD _____

List all drug allergies (along with reactions):

_____**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/	Y N Drug Allergies		Y N Back pain
Immunologic	Y N Seasonal Allergies		Y N Neck pain/stiffness
Neurological:	Y N Tremors	Ear/Nose/	Y N Earache
	Y N Seizures	Throat/Mouth	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: