Patient History Form

Please complete the following form and answer all questions so that we may have an accurate record of your medical history. Thank you.

Chart #:

Today's Date:

Name: **Date of Birth:** **Referring Physician:**

Allergy to:		**Reaction**
Latex	Yes ☐ No ☐	
Shellfish	Yes ☐ No ☐	
X-Ray Dye	Yes ☐ No ☐	
Iodine	Yes ☐ No ☐	

Current Medications, Vitamins & Minerals ☐ **NONE**	**Dose**	**Frequency**

Drug Allergies: ☐ **NONE**	**Reaction**

List current Pharmacy:

Name:

Location:

Phone:

Past Medical Problems:	**YES**	**NO**
Heart Disease	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐
Lung Disease	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Bowel Problems	☐	☐
Stroke/Seizure	☐	☐
Kidney Problems	☐	☐
Bleeding Problems	☐	☐
HIV	☐	☐
Hepatitis	☐	☐
Cancer	☐	☐

Questions:	
All Patients: Have you had a flu vaccination in the current flu season?	Yes ☐ No ☐ **MM/YY:**
All Patients: Have you been hospitalized in the last 30 days? (Not Emergency Room)	Yes ☐ No ☐
Adults 65 years or older: Have you had a Pneumonia Vaccinations in the last 12 months?	Yes ☐ No ☐
All Patients: Have you had a fall within the last 2 years or problems with your gait or balance?	Yes ☐ No ☐
Women ages 50-74: Have you had a Mammogram in the last 2 years?	Yes ☐ No ☐

Social History

Current Smoker? (e-cig./vape) Yes ☐ No ☐

Previous Smoker? (e-cig./vape) Yes ☐ No ☐

Do you Drink Alcohol?

No	☐
Monthly or less	☐
2 to 4 times a month	☐
2 to 3 times a week	☐
4 or more times a week	☐

Recent Symptoms		
Unexplained Weight Loss	Yes ☐	No ☐
Dry Eyes	Yes ☐	No ☐
Dry Mouth	Yes ☐	No ☐
Leg Swelling	Yes ☐	No ☐
Shortness of Breath	Yes ☐	No ☐
Constipation	Yes ☐	No ☐
Involuntary Urine Loss	Yes ☐	No ☐
Lower Extremity Weakness	Yes ☐	No ☐
Dry Skin	Yes ☐	No ☐
Difficulty Walking	Yes ☐	No ☐
Psychiatric Problems	Yes ☐	No ☐
Impaired Sex Drive	Yes ☐	No ☐
Easy Bleeding	Yes ☐	No ☐
Rash	Yes ☐	No ☐

Family History : ☐ **Unknown**		
Kidney Cancer	Yes ☐	No ☐
Kidney Problems	Yes ☐	No ☐
Kidney Stones	Yes ☐	No ☐
Prostate Cancer	Yes ☐	No ☐
If so, any of these immediate relatives?		
Father	Yes ☐	No ☐
Brother	Yes ☐	No ☐
Son	Yes ☐	No ☐
Breast Cancer	Yes ☐	No ☐
If so, any of these immediate relatives?		
Mother	Yes ☐	No ☐
Sister	Yes ☐	No ☐
Daughter	Yes ☐	No ☐

♦Female Patients only: (Family History)		
Ovarian Cancer	Yes ☐	No ☐
Uterine Cancer	Yes ☐	No ☐
Cervical Cancer	Yes ☐	No ☐

Past Surgeries: ☐ **NONE**	
Kidney Surgery	☐
Lithotripsy	☐
Kidney Stone Surgery	☐
Bladder Surgery	☐
Bladder Tumor Removal	☐
Prostate Biopsy	☐
Prostatectomy	☐
Prostate Surgery	☐
Joint Replacement Surgery	☐
Open Heart Surgery	☐
Heart Valve Surgery	☐
Heart Stent Procedure	☐
Colon Surgery	☐
Gallbladder Surgery	☐
Hernia Repair	☐
Cataract Surgery	☐
C-Section	☐
Cystocele (Drop Bladder)	☐
D & C	☐
Ectopic Pregnancy	☐
Hysterectomy	☐
Laparoscopy	☐
Cervical Leep Conization	☐
Ovaries Removed (Both)	☐
Ovary Removed (One)	☐
Rectocele Repair	☐
Tubal Ligation	☐
Uterine Ablation	☐
Vaginal Cancer Treatment	☐
Vasectomy	☐
Other Abdominal Surgery	☐
NONE listed above	☐