Name: _____ Date: _____

Referring Doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

How long have you had this problem/pain?_____

What improves or worsens the problem/pain?_____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous, or does it come and go? _____

Describe the pain? (sharp/dull, etc). _____

Have you tried any medicine/treatment or seen a doctor for this problem before this visit? _____

_____

PAST MEDICAL HISTORY

Please indicate if you have or have had any of the following diseases or conditions:

Adenocarcinoma prostate
ADD
ADHD
Alcoholism
Allergies
Alzheimer's disease
Anemia (type) _____
Angina
Anorexia
Anxiety disorder
Arthritis
Arrhythmia
Aortic aneurysm
Aortic insufficiency
Aortic stenosis
Asthma
Atrial fibrillation
Back pain
Benign prostatic hypertrophy
Bi-polar disorder
Bleeding disorder
Blindness
Brain tumors
Breast cancer
Breast disease
Bronchitis
Cataracts
Cerebrovascular disease
Cholecystitis
Cholelithiasis
Chronic fatigue syndrome
Chronic liver disease
Chronic lung disease
Chronic renal failure
Chronic renal insufficiency
Colitis
Constipation
Colon cancer
Colon condition
Congenital heart disease
Congenital heart failure
Crohn's disease
Deafness
Deep venous thrombosis
Depression
Deviated septum
Diabetes mellitus non insulin dep
Diabetes mellitus insulin dep
Diabetes mellitus uncontrolled
Diarrhea
Eating disorder
Ear infections
Electrical injury
Elevated PSA
Emphysema
Enlarged heart
Epilepsy
Fibrocystic breast disease
Fibromyalgia
Gastric cancer
GERD
Glaucoma
Goiter
Gout
Hay fever
Heart attack
Heart disease (type)_____
Heart murmor
Heart valve prob (type)___
Hemorrhoids
Hepatitis
Herniated disc
Hiatal hernia
Hypercholesterolemia
Hyperlipidemia
Hypertension progressive
Hypertension, severe
Impaired glucose tolerance
Inflammatory bowel disease
Irritable bowel disease
Kidney disease (type)____
Kidney infection
Kidney stones
Infectious disease
Laryngeal cancer
Leukemia
Liver disease
Lipid disorder
Lung disease (type)_____
Lung cancer
Lymphoma
Malaise
Melanoma
Mental illness
Migraine
Mitral insufficiency
Mitral stenosis
Mitral valve prolapsed
Morton's neuroma
Mumps
Nervous breakdown
Obesity
Organic brain syndrome
Osteoporitis
Pancreatic cancer
Pancreatitis
Peptic ulcer
Phlebitis
Polio
Prostate cancer
Prostatitis
Pulmonary embolism
Rectal cancer
Rectal fissure
Renal failure
Rheumatic fever
Sickle cell anemia
Stroke
Suicide attempt
Thyroid disease
Tuberculosis
Other:

SURGICAL HISTORY

Please indicate if you have had any of the following surgeries and when:

Amputation
Angioplasty
Aortic aneurysm repair
Appendectomy
Arthroscopic surgery
Back surgery
Bariatric surgery
Biopsy prostate
Bladder surgery
Bowel resection
Brachytherapy
Brain surgery
Breast surgery
CABG
Carotid artery surgery
Carpal tunnel surgery
Cataract surgery
Cervical spine surgery
Cholecystectomy
Circumcision
Colon resection
Colonoscopy
Corneal surgery
Cystoscopy
Cysto-TUR-fulguration
Cyst removal
Ear surgery
EGD
EGD/dilation esophagus
Epididymectomy
ESWL
Eye surgery
Facial surgery
Fissurectomy
Foot surgery
Gastric surgery
Hand surgery
Heart surgery
Heart transplant
Hemorrhoidectomy
Herniorrhaphy
Hip surgery
Hydrocelectomy
Ileostomy
Ilioconduit
Indigo laser surgery
Inguinal heriorrhaphy
Knee surgery
Laminectomy
Laparoscopy
Laparotomy
Leg surgery
Liver surgery
Liver transplant
Lumpectomy
Lung surgery
Lymphatic node dissection
Lysis adhesions
Mastectomy
Mastoid surgery
Meatotomy
Nasal surgery
Needle biopsy prostate
Nephrectomy
Nephrolithotomy
Nissen fundoplication
Orchiectomy
Pacemaker insertion
Parathyroidectomy
Penile implant
PEG
PE tubes
Pilonidal cyst incision
Radical prostatectomy
Renal transplant
Rotator cuff surgery
Septoplasty
Sinus surgery
Skin grafting
Spermatocelectomy
Splenectomy
Stomach surgery
Tonsil surgery
Thyroid surgery
TMJ surgery
TUMT prostate
TUR prostate
Umbilical hernia
Ureterscopy
Varicocelectomy
Vasectomy
Vein stripping
Ventral hernia repair
VLAPP
Other

FAMILY HISTORY

Please indicate which family member has/had any of the following:

Arthritis
Bedwetting
Bladder cancer
Breast cancer
Cancer (site unknown)
Crohn's disease
Depression
Diabetes mellitus
Gout
Heart attack
Heart disease
Hypertension
Kidney disease
Kidney stones
Laryngeal cancer
Leukemia
Lung cancer
Malignant melanoma
Multiple sclerosis
Pancreatic cancer
Prostate cancer
Stroke
Thyroid disease
Tuberculosis
Other:

SOCIAL HISTORY **Please provide the following:**

Marital Status:

____Single ____Married ____Separated ____Divorced ____Widowed ____Life Partner ____Common Law Spouse

Dependants: Please indicate # of each, if you have:

____Sons ____Daughters ____Stepchildren ____Adopted ____Foster ____Parents _____Grandparents

Occupation: (please circle one that applies): None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, or Other

Hobbies: (please circle any that apply to you) None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol consumption: ____None ____Yes Occasional/social # drinks per day ____

Tobacco per day: ____None ____Yes #____ Packs/day ____Cigarettes/day ____Smokeless Tobacco

If you previously stopped, when? _____

Recreational drugs: ____None If yes, please list: _____

Caffeinated beverages: None Low Moderate Excessive

ALLERGIES - please list ALL types (Drug, seasonal, pets, animals, environmental, foods)

_____

_____

_____

Recent Foreign Travel: **NONE**
Americas - Canada**,** Mexico, Latin America, South America, Other _____
(please circle all that apply) **World wide** - Europe, Africa, Middle East, Asia, Australia, Other _____

CURRENT MEDICATIONS - please list ALL medications you are currently taking. Include any over the counter drug(s).

Drug Name	**Strength**	**Directions/How you take it**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name: _____ **Phone#:** _____

By what method did you choose our practice?

____Referring physician ____Friend ____Yellow pages ____Insurance Co. ____Other