Medical History Form

Patients Name: ____DOB:_____________
Email Address: ____
Date Completed_______________
Current: (WT) _______________ (HT) ______________ (BMI) _______________
Vital Signs: (BP) ____________ (P) ____________ (R) ____________ (T) __________
Reason for visit: ____

Do you have an advance directive: ❑Yes ❑No / Name: ______________________________________
Relationship to above name: ___________________

Do you wish information about directives: ❑Yes ❑ No

Referring Provide or Primary Care Physician: ______________________________________

Past Medical History: (circle all that apply)
Asthma, Bleeding Disorder, Bronchitis, Chest Pain, Depression, Diabetes, Emphysema, Gout, Heart Attack, Heart Disease, Heart Murmur, Heart Valve problems, High Blood Pressure, Irregular Heartbeat, Jaundice, Kidney Disease, Stroke, Thyroid Problems, Tuberculosis, Ulcers,
Cancer: (please list) ____
Other: ____

Past Surgical History: List personal past surgeries
____
____
____
____

Medications: List name(s), dosage, frequency (this includes herbals, vitamins/minerals/dietary and nutrient supplements)

Drug Name	Dose	Frequency

Allergies to medication(s):____
Please list if allergic to Iodine, Latex, Shellfish, X-ray Dye, Other: ____________________________________

Past Family History:
(Circle all that apply to your immediate family and indicate the family member/mother, father, sister brother)
Diabetes________________________**Heart Attack**________________**Heart Disease**_________________
High Blood Pressure______________**Kidney Disease**______________**Stroke**________________________
Cancer: (type) ____

Social History:
Do you smoke? ❑ Yes ❑ No / did you smoke? ❑ Yes ❑ No / If YES, for how long? _______________
Interested in counseling on stopping smoking ❑ Yes ❑ NO
Do you drink alcoholic beverages? ❑Yes ❑No / If YES, how much and how often? _________________
Occupation: ____
***COMPLETE BOTH SIDES OF THIS FORM**

Do you have or have you had any of the following problems.
Please circle YES or NO and explain all YES answers
Updated and reviewed_________/Update and reviewed_________/Update and reviewed________

Constitutional Symptoms: Fever Weight loss or gain	 YesNo____ Yes/No____
Eyes: Blurred or double vision Cataracts Glaucoma	 Yes/No____ Yes/No____ Yes/No____
Respiratory: Wheezing A frequent cough Shortness of breath Asthma/Bronchitis/ Emphysema/ Pneumonia Tuberculosis	 Yes/No____ Yes/No____ Yes/No____ Yes/No____ Yes/No____
Genitourinary: Frequent urination Painful urination Nocturia (getting up to urinate at night) Blood in urine Incontinence (urinary leakage) Urinary tract infections Slow stream	 Yes/No____ Yes/No____ Yes/No____ Yes/No____ Yes/No____ Yes/No____ Yes/No____
Integumentary: Skin rash	 Yes/No____
Hematologic/Lymphatic: Enlarged lymph nodes Bleeding problems History of cancer	 Yes/No____ Yes/No____ Yes/No____
Cardiovascular: Chest pain Rheumatic fever Rapid heartbeat High blood pressure Pain in legs (calf) with walking	 Yes/No____ Yes/No____ Yes/No____ Yes/No____ Yes/No____
Gastrointestinal: Abdominal pain Nausea and or vomiting Rectal bleeding Diarrhea/Constipation Hepatitis	 Yes/No____ Yes/No____ Yes/No____ Yes/No____ Yes/No____
Musculoskeletal: Joint pain Back pain Arthritis	 Yes/No____ Yes/No____ Yes/No____
Neurologic: Seizures Paralysis Tingling	 Yes/No____ Yes/No____ Yes/No____
Endocrine: Thyroid problems Diabetes Mellitus Increase thirst/Heat or cold intolerance Excessive urination	 Yes/No____ Yes/No____ Yes/No____ Yes/No____

Updated & Reviewed 07/2020

The Urology Clinic