Patient History Form (Please Print) Date:_____

Last Name:_____First Name:_____MI_____

Date of Birth _____/_____/_____Height_____Weight_____

What is the main reason for your visit? (Describe your problem in detail)

_____

_____

Allergies and Medications

List your current allergies:

_____

_____

List all your current medications and dosage: (you may provide a list if available)

_____

_____

_____

_____

Provide the name, address and phone number of your preferred pharmacies.

_____

_____

Past Medical and Surgical History

List any personal illnesses/diagnosis/disease and when they occurred: Example (Bladder cancer, Diabetes)

_____

_____

_____

List any procedures/surgeries you have had. Please provide approximate date of procedure/surgery:

_____

_____

***DO YOU HAVE A PACEMAKER OR IMPLANTABLE DEVICE? YES ☐ NO ☐**

IF "YES" PLEASE DESCRIBE:_____

Family History

Circle any illnesses in your immediate family: *Include the relationship to you :* **☐ NONE /UNKNOWN**

Prostate Cancer_____
Prostate Problems_____
Bladder Cancer_____
Kidney Cancer_____
Breast Cancer_____
High Blood Pressure_____
Diabetes_____

Skin Cancer_____
Tuberculosis_____
Kidney Stones_____
Thyroid Problems_____
Stroke_____
Parkinson's Disease_____

Uterine Cancer_____
Kidney Failure_____
Other: _____

Social History (Circle answer)

Marital Status: Married Single Divorced Widowed Separated Unknown

Smoking Status: Current Every Day Smoker Current Some Day Smoker Former Smoker
Never Smoker Smoker/status unknown Unknown

If ever Smoked answer the following:

How much do you/did you smoke? _____ **For how many years did/have you smoked?** _____

Do you Drink Alcohol? Yes Not Any More Never Drank

Type(s) of alcohol consumed: Beer Wine Alcohol **Drinking Habit:** Social Light Moderate Excessive

How many caffeinated drinks to you have each day? 0 1 2 3 4+ **Have you had a blood transfusion?** Yes No

Language English Spanish French German Portuguese Russian Chinese Japanese Italian Other

Race White Black/ African American American Indian/Alaska Native Eskimo Hispanic
Asian Pacific Islander Unknown

Review of Systems (Circle all that apply)

Constitutional: Fever Chills Weight loss Other: _____

Eyes: Blurry Vision Double Vision Cataracts Other: _____

Ears, Nose Mouth and throat: Hearing Loss Nasal Stuffiness Sore Throat Other: _____

Cardiovascular: Chest Pain Swollen Ankles Irregular Heartbeat Other: _____

Respiratory: Shortness of Breath Wheezing Chronic Cough Other: _____

Gastrointestinal: Abdominal Pain Nausea/Vomiting Change in Bowels Other: _____

Genitourinary: Incontinence Painful Urination Blood in Urine Other: _____

Musculoskeletal: Chronic back pain Chronic neck pain Sore Muscles Other: _____

Integumentary/Skin: Rash Persistent Itching Skin Cancer History Other: _____

Neurological: Numbness Tingling Dizziness Other: _____

Hematologic/Lymphatic: Swollen Glands Abnormal Bleeding Transfusion History Other: _____