MEDICAL HISTORY

Name ________________________________Date of Birth __________ Today's Date __________ Family M.D.__________________

Reason for visit____

Allergies & Reaction: ____ **Height** _________ **Weight** _________

Medication: Please list all medications and dosages. Include over the counter supplements or vitamins you are currently taking.

__________________________ _____________________________ __________________________ ________________________

__________________________ _____________________________ __________________________ ________________________

Medical History: List all current and past medical conditions:

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Surgical History: List all surgeries:

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FAMILY HISTORY	Father	Mother	Brother	Sister	Children	**SOCIAL HISTORY**	**YES**	
Cancer						Currently smoke cigarettes		Packs/day ____# years____
Diabetes						Quit smoking cigarettes		When?
Heart Disease						Alcohol drinker		Amount per day
Kidney Disease						Caffeine		Type: ____Cups per day
Kidney Stones						Recreational drugs		How often/week_____
Stroke						Exercise		How often/week_____

MARITAL STATUS:	(Circle) Married Widowed Divorced Single	**SPOUSE'S NAME:**	
OCCUPATION:		**RETIRED FROM:**	

Review of Systems: Please check next to each box if you are **currently** experiencing any of the following:

URINARY	**YES**	**URINARY**	**YES**
Urinary tract infection		Urinary urgency	
Pain or burning upon urination		Difficulty starting urination – need to push	
Blood in the urine		Urinating – slow stream	
Frequent urination – day / night		Difficulty stopping urination	
Urinary incontinence / leakage		Interrupted stream during urination	
Kidney stone		Unusual large volume of urine	

GENITO-REPRODUCTIVE (MALE)	**YES**	**GENITO-REPRODUCTIVE (FEMALE)**	**YES**
Testicular pain		Urine Incontinence – stress / urge	
Lumps in testicles or scrotum		Vaginal bleeding since menopause	
Decrease in testicular size		Taking female hormones	
Diminished sexual drive		Infertility	
Difficulty with an erection		Decrease sexual drive	
History of sexually transmitted disease(s)		History of sexually transmitted disease(s)	
Penile discharge		Menopause	
Infertility			

NEUROLOGICAL	**YES**	**GENERAL**	**YES**
Headaches / Migraines		Weakness	
Stroke / Seizures		Difficulty sleeping	
Paralysis / Weakness of limb(s)		Weight gain / loss	
CARDIOVASCULAR	**YES**	Chill / fever	
High blood pressure			
Arrhythmias (e.g. atrial fibrillation)			
MI / Coronary artery disease/ heart attack			

MEDICAL HISTORY