Medical History

Name ______________________________________ Age ____ Today's Date ______________ **Family M.D.** ________________________

Reason for visit : ____

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Medications: Please list all medications and dosages. Include vitamins and supplements you are currently taking.

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

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Height: ___________

Weight: ___________

Medical History: List all Current and Past Medical Conditions

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Allergies: ____

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: ____________#cup/day___
Kidney stones						Recreational drugs		Type: ____________________
stroke						Exercise		How often/week ____________
Marital status: circle Married Widowed Divorced Single						If married, **spouse's name**________ ______________		
Occupation:						**Retired from**:		

Review of Systems: Please place check next to each box if you are currently having any of these problems:

Night sweats		Ringing in ears		Urinating: slow start	
Chills		Sinus pain		Urinating: slow stream	
Weight gain		Dizziness		Painful urination	
Weight loss		Chest pain		Interrupted stream during urination	
Loss of appetite		Irregular heart beat		Need to push to urinate	
Fever		Swollen legs		Urinary urgency	
Weakness		Swollen glands		Urinary frequency	
Fatigue		Easy bruising		Urinary incontinence/leakage	
Back pain		Nausea		Blood in urine	
Joint pain		Heartburn		urinary tract infection	
Cough		Vomiting		Nighttime urination	
Wheeze		Abdominal pain		Headache	
Shortness of breath		Diarrhea		Tingling/numbness	
Vision problem		Constipation		Seizures	
Cold		Blood in stool		Depression	
Cough		Hemorrhoids		High stress level	
Nose bleed		Infertility		Sleep disturbances	
Hearing loss		Difficulty with erection		Anxiety	
Change in voice		Diminished sexual drive		menopause	
Sore throat		Penile discharge			