

CONFIDENTIAL MEDICAL HISTORY

Please answer all questions completely, if none or not applicable please write "None".

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____

Name _____ Birth Date _____

Primary Doctor _____ Referred By _____

What is the reason for your visit? (Describe in detail): _____

CURRENT MEDICATIONS (dose, how long on medication, and reason including vitamins, herbs and Over-the-counter medications)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

DO YOU TAKE ASPIRIN? _____ If yes, most recent dose _____

ALLERGIES (medications, foods, etc. Describe reaction.)

MEDICAL HISTORY - Please list all medical problems that you currently have or have had in the past.

1. _____
2. _____
3. _____
4. _____

SURGICAL HISTORY

OPERATION	REASON	HOSPITAL	DATE
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

DO YOU SMOKE? YES NO Quit – How long ago? _____
 If yes, number of packs per day? _____ For how long? _____

DO YOU DRINK ALCOHOL? YES NO If so, how much and how often? _____
 Beer? _____ Wine? _____ Hard liquor? _____

FAMILY'S HEALTH HISTORY (if alive, age & health status; if deceased, age at death & cause)

Mother _____ Breast Cancer? Yes No
 Father _____ Prostate Cancer? Yes No

Any blood relatives with a history of prostate, bladder, kidney or other urologic disorders, cancer, or stones?

Prostate Cancer? Yes No if Yes, how related? _____
 Bladder Cancer? Yes No if Yes, how related? _____
 Kidney Cancer? Yes No if Yes, how related? _____
 Urinary /Kidney Stones? Yes No if Yes, how related? _____

DO YOU HAVE OR HAVE YOU HAD? (Please circle the correct answer)

Bleeding Problems..... yes no	Blood Transfusions.....yes no
Steroid/Prednisone..... yes no	Anemia.....yes no
Diabetes..... yes no	Thyroid Problems..... yes no
Phlebitis..... yes no	Stomach Ulcers..... yes no
Strokes..... yes no	Constipation..... yes no
Chronic Fevers..... yes no	Hiatal Hernia..... yes no
Glaucoma..... yes no	Diarrhea..... yes no
Hepatitis..... yes no	TB (tuberculosis)..... yes no
High Blood Pressure..... yes no	Asthma..... yes no
Heart Problems..... yes no	Emphysema/Bronchitis.....yes no
Heart Attack.....yes no	Pneumonia..... yes no
Chest Pain..... yes no	Epilepsy/Seizures.....yes no
Heart Failure.....yes no	Rheumatic Fever..... yes no
Ankle Swelling..... yes no	Cancer..... yes no
Most recent EKG Date: _____	Where _____
Heart Murmur..... yes no	Artificial Joint..... yes no
Weight loss..... yes no	Parkinson's Disease..... yes no
How much? _____	Mumps..... yes no
Over how long? _____	Have you been told to take prophylactic
Are you trying to lose weight?..... yes no	antibiotics with dental work..... yes no

Reviewed by Dr: _____ Date _____