

PLEASE PRINT FORM, FILL OUT BY HAND AND BRING TO YOUR NEXT OFFICE VISIT.

LAST NAME _____ FIRST NAME _____

TODAY'S DATE: ____/____/____ AGE: _____

WHAT BRINGS YOU IN TODAY? (DESCRIBE IN DETAIL) _____

HISTORY OF PRESENT ILLNESS

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT TREATMENTS HAVE YOU TRIED? _____

HAVE THEY WORKED? _____

IF THERE IS DISCOMFORT, WHERE IS IT? _____

ARE THERE ANY ASSOCIATED ISSUES? _____

HAVE YOU HAD BLOOD IN THE URINE? Y N

ERECTILE DYSFUNCTION OR CURVATURE? Y N

PAIN WITH URINATION? Y N

4+ = 3-5

Physician Use A/P

- 1. Med Complex
3 4 5
- 2. Data
3 4 5
- 3. Decision Making
3 4 5

PAST MEDICAL HISTORY

DO YOU HAVE ANY ALLERGIES? _____

DO YOU TAKE MEDICATION? (LIST HERE, INCLUDE HERBAL/ OTC) _____

DO YOU TAKE ASPIRIN? YES/ NO

DO YOU HAVE ANY MEDICAL PROBLEMS? (PLEASE LIST) _____

HEART ISSUES? _Y/N_____

BLEEDING OR CLOTTING PROBLEMS? _Y/N_____

HAVE YOU EVER HAD SURGERY? (PLEASE LIST ALL INCLUDE CHILDHOOD) _____

FAMILY HISTORY

FATHER: AGE? ____ LIVING? Y N MEDICAL PROBLEMS? _____

MOTHER: AGE? ____ LIVING? Y N MEDICAL PROBLEMS? _____

SIBLINGS: # OF SISTERS _____ MEDICAL PROBLEMS? _____

OF BROTHERS _____ MEDICAL PROBLEMS? _____

PROSTATE CANCER? Y N IF Y, WHO? _____

HEART DISEASE? Y N IF Y, WHO? _____

SOCIAL HISTORY

WHAT WORK DO YOU DO? _____

DO YOU SMOKE? Y / N DO YOU DRINK ALCOHOL? Y / N. # DRINKS PER WEEK? _____

HAVE YOU EVER SMOKED? Y / N FOR HOW LONG? _____

DO YOU USE DRUGS? Y / N IF SO, WHAT? _____

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING? CIRCLE YES OR NO; EXPLAIN ANY YES ANSWER IN MARGIN.

CONSTITUTIONAL:

FEVERS?	Y	N	WEIGHT LOSS?	Y	N
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VISION:

BLURRED VISION?	Y	N	TEMPORARY BLINDNESS IN ONE EYE?	Y	N
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EAR/NOSE/THROAT

DEAFNESS?	Y	N	SWOLLEN LYMPH NODES?	Y	N
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RESPIRATORY:

SHORTNESS OF BREATH	Y	N	CHRONIC COUGH	Y	N
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CARDIOVASCULAR:

CHEST PAIN	Y	N	PALPITATIONS	Y	N
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GASTROINTESTINAL:

VOMITING	Y	N	ABDOMINAL PAIN	Y	N
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MUSCULOSKELETAL:

JOINT PAIN	Y	N	MUSCLE ACHES	Y	N
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NEUROLOGICAL:

DIZZINESS	Y	N	FAINTING	Y	N
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SKIN:

RASHES/ LESIONS	Y	N	ITCHING	Y	N
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ENDOCRINE:

EXCESSIVE THIRST	Y	N	TOO HOT/ COLD	Y	N
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LYMPHATIC:

SWOLLEN GLANDS	Y	N	NEW LUMPS	Y	N
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10+ = 4-5

Physician Signature