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Using Adobe Acrobat Reader 8.0 or later

# Patient History

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

## TOBACCO USE

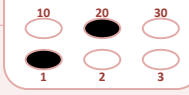
What is your smoking status? current (every day) ○ current (some days) ○ previous ○ never ○

At what age did you begin smoking?

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke or did you previously smoke per day?

**EXAMPLE**
If you started smoking at the age of 21, you would fill in the ovals like this:



10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

How many cigars or pipes do you smoke per week?
0 ○ <1 ○ 1-2 ○
3-5 ○ 6-9 ○ 10+ ○

How many cans of smokeless / chewing tobacco do you use per week?
0 ○ <1/2 ○ 1/2 ○
1 ○ 2 ○ 3+ ○

Are you exposed to passive (second hand) smoke? yes ○ no ○

## ALCOHOL USE

How often do you use alcohol? (Number of times...) never ○ 1 ○ 2 ○ 3 ○
4 ○ 5 ○ 6 ○ 7+ ○
(Per...) week ○ month ○ year ○

(If you marked "never", please skip to Drug Use section)

What type(s) of alcohol do you drink? beer ○ wine ○ liquor ○

How many drinks do you have per occasion? 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How often do you have more than five drinks per occasion? never ○ occasionally ○
rarely ○ frequently ○

## DRUG USE

none ○ current ○ previous ○ prefer to discuss with physician ○

## HIV HIGH RISK BEHAVIOR?

(HIV Risk Factors: IV drug use, More than one sexual partner, Sex with a prostitute, Unprotected sexual contact, Contact with contaminated injection equipment.)

yes ○ no ○ prefer to discuss with physician ○

## HABITS

Caffeine
-type(s) of caffeine: coffee ○ tea ○ soft drinks ○
-drinks per day: occasionally ○ 0 ○ 1-2 ○
3-4 ○ 5-6 ○ 7+ ○

Exercise
-type(s) of exercise: bicycling ○ running ○ swimming ○
walking ○ aerobics ○ other ○
-times per week: occasionally ○ 0 ○ 1-2 ○
3-4 ○ 5-6 ○ 7+ ○

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# Patient History

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## YOUR Medical History

Please indicate if **YOU** have a history of the following:

- Alcohol Abuse
- Anemia
- Anesthetic Complication
- Anxiety Disorder
- Arthritis
- Asthma
- Autoimmune Problems
- Birth Defects
- Bladder Problems
- Bleeding Disease
- Blood Clots
- Blood Transfusion(s)
- Bowel Disease
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Depression
- Diabetes
- Growth / Development Disorder
- Heart Attack
- Heart Disease
- Heart Pain / Angina
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- HIV
- Hives
- Kidney Disease
- Kidney Stones
- Liver Disease
- Lung / Respiratory Disease
- Lung Cancer
- Mental Illness
- Migraines
- Osteoporosis
- Prostate Cancer
- Rectal Cancer
- Reflux / GERD
- Seizures / Convulsions
- Severe Allergy
- Sexually Transmitted Disease
- Skin Cancer
- Stroke
- Suicide Attempt
- Thyroid Problems
- Ulcer
- Other Disease, Cancer, or Significant Medical Illness

- **NONE of the Above**

## FAMILY Medical History

Please indicate if **YOUR FAMILY** have a history of the following:
**(ONLY** include parents, grandparents, siblings, and children)

- **Family History Unknown**

- Anesthetic Complication
- Bladder Problems
- Bleeding Disease
- Breast Cancer
- Colon Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Kidney Stones
- Lung / Respiratory Disease
- Disease of the Urinary Tract
- Prostate Cancer
- Other Cancer

- **NONE of the Above**

- Mother, Grandmother, or Sister developed heart disease before the age of 65
- Father, Grandfather, or Brother developed heart disease before the age of 55

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# Patient History

Please answer every question

## SURGICAL HISTORY

Please mark all surgeries you have had.

- ◯ I have had NO Surgeries.

### Urology Surgery

- ◯ Prostate TURP
- ◯ Prostate Removal
- ◯ Kidney Removal
- ◯ Kidney Stone Surgery
- ◯ Bladder Tack
- ◯ Bladder Stone
- ◯ Bladder Cancer Surgery
- ◯ Bladder Removal
- ◯ Inguinal Hernia Surgery
- ◯ Vasectomy

### General Surgery

- ◯ Appendectomy
- ◯ Gallbladder Surgery
- ◯ Tonsillectomy
- ◯ Sinus Surgery
- ◯ Colon Polyps
- ◯ Colon Cancer Surgery
- ◯ Anal Fissure Repair
- ◯ Thyroid Surgery
- ◯ Cataracts
- ◯ Hemorrhoidectomy

### Cardiac and Vascular Surgery

- ◯ Heart Valve Surgery
- ◯ Carotid Artery Surgery
- ◯ Pacemaker
- ◯ Cardiac Stent(s)
- ◯ Heart Bypass

### Ortho Surgery

- ◯ Knee Surgery
- ◯ Knee Replacement
- ◯ Hip Replacement
- ◯ Hip Fracture
- ◯ Shoulder Surgery
- ◯ Foot Surgery

### GYN Surgery / Breast Surgery

- ◯ Breast Implant(s)
- ◯ Breast Reduction
- ◯ Mastectomy
- ◯ Tubal Ligation
- ◯ Caesarean Section
- ◯ Dilation and Curettage (D & C)
- ◯ Ovary Removal
- ◯ Hysterectomy

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# Patient History

Please answer every question

## REVIEW OF SYSTEMS

**Please mark only the symptoms you CURRENTLY are experiencing.**

**Mark all that apply ---- if no symptoms, please mark "NONE"**

| | | | |
|---|---|---|---|
| **General** | | | |
| | weight loss ◯ | persistent infections ◯ | |
| fever ◯ | weight gain ◯ | fatigue ◯ | NONE ◯ |
| **Eyes** | | | |
| | visual disturbances ◯ | glasses / contacts ◯ | NONE ◯ |
| **Ear, Nose, and Throat** | | | |
| | hearing loss ◯ | sinus pain ◯ | |
| | seasonal allergies ◯ | oral ulcers ◯ | NONE ◯ |
| **Cardiovascular** | | | |
| | chest pain ◯ | palpitations ◯ | |
| difficulty breathing on exertion ◯ | shortness of breath ◯ | swelling hands / feet ◯ | NONE ◯ |
| **Respiratory** | | | |
| | | chronic cough ◯ | |
| wheezing ◯ | difficulty breathing ◯ | coughing blood ◯ | NONE ◯ |
| **Breast** | | | |
| mass/lump ◯ | breast pain ◯ | nipple discharge ◯ | NONE ◯ |
| **Gastrointestinal** | | | |
| | | indigestion ◯ | |
| nausea ◯ | constipation ◯ | bloody stool ◯ | |
| vomiting ◯ | chronic diarrhea ◯ | hemorrhoids ◯ | |
| change in bowel habits ◯ | abdominal pain ◯ | excessive gas ◯ | NONE ◯ |
| **Female Genitourinary (Women Only)** | | | |
| pelvic pain ◯ | vaginal dryness ◯ | painful urination ◯ | |
| urinary frequency ◯ | vaginal discharge ◯ | painful menstruation ◯ | |
| urinary urgency ◯ | vaginal itch or burning ◯ | blood in urine ◯ | |
| excessive urination at night ◯ | painful intercourse ◯ | urine leakage ◯ | NONE ◯ |
| **Male Genitourinary (Men Only)** | | | |
| | difficulty starting stream ◯ | incomplete emptying ◯ | |
| urine leakage ◯ | urinary frequency ◯ | testicular mass ◯ | |
| painful urination ◯ | urinary urgency ◯ | testicular pain ◯ | |
| change in urinary stream ◯ | impotence ◯ | penile lesions ◯ | |
| excessive urination at night ◯ | urethral discharge ◯ | blood in urine ◯ | NONE ◯ |
| **Musculoskeletal** | | | |
| joint pain ◯ | muscle pain ◯ | muscle weakness ◯ | NONE ◯ |
| **Skin** | | | |
| dry skin ◯ | rash ◯ | new sore/lesion ◯ | |
| change in wart or mole ◯ | hives ◯ | skin ulcer ◯ | NONE ◯ |
| **Neurologic** | | | |
| fainting ◯ | numbness ◯ | seizures ◯ | |
| decreased memory ◯ | trouble walking ◯ | headaches ◯ | NONE ◯ |
| **Psychiatric** | | | |
| anxiety ◯ | frequent crying ◯ | fearful ◯ | |
| panic attacks ◯ | depression ◯ | change in sleep pattern ◯ | NONE ◯ |
| **Endocrine** | | | |
| | | cold intolerance ◯ | |
| hair changes ◯ | heat intolerance ◯ | hot flashes ◯ | NONE ◯ |
| **Heme/Lymphatic** | | | |
| | easy bruising ◯ | excessive bleeding ◯ | NONE ◯ |