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Direction of Feed

Patient History

Please answer every question

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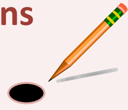
Marking Instructions

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



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

TOBACCO USE

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

At what age did you begin smoking? 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

If you quit smoking, at what age did you quit? 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

How many cigarettes do you currently smoke or did you previously smoke per day? 10 20 30 40 50 60 70 80 90 / 1 2 3 4 5 6 7 8 9

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:
10 20 30
1 2 3

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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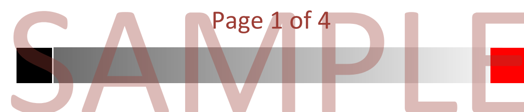

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Direction of Feed

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 Health History

◯ **Family History UNKNOWN** ◯ **No Significant Family Health History**

Please indicate which family members have had these illnesses:	Father	Mother	Brother	Sister	Son	Daughter
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	◯	◯	◯	◯	◯	◯

- ◯ Grandparent had a history of cancer or urological problems
- ◯ 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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Direction of Feed

Patient History

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SURGICAL HISTORY

Please mark all surgeries you have had.

Patient's name: ____________________

- I have had NO Surgeries

Urology Surgery

- Radical Prostatectomy
- Brachytherapy
- 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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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

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