Name: ______________________ Acct No: __________ Date: ______

SURGICAL HISTORY

Please CHECK if you have had any of the following surgeries:

- ☐ Angioplasty for heart
- ☐ Appendectomy
- ☐ Biopsy of Prostate
- ☐ Bowel Resection
- ☐ Carotid Artery Surgery
- ☐ Circumcision
- ☐ Cystoscopy
- ☐ Heart Bypass Surgery
- ☐ Hernia Surgery
- ☐ Hysterectomy (Vaginal or Abdominal)
- ☐ Knee Surgery (L or R or both)
- ☐ Pacemaker Insertion
- ☐ Stomach Surgery
- ☐ Tonsil Surgery
- ☐ Aortic Aneurysm Repair
- ☐ Back Surgery
- ☐ Bladder Surgery
- ☐ Breast Surgery (L or R or both)
- ☐ Cataract Surgery
- ☐ Colon Resection
- ☐ Deliveries (Vaginal or C-Section)
- ☐ Hemorrhoid Surgery
- ☐ Hip Surgery (L or R or both)
- ☐ Kidney Surgery
- ☐ Lung Surgery (L or R or both)
- ☐ Radical Prostatectomy
- ☐ Thyroid Surgery
- ☐ Vasectomy

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

______ Single ______Married ______Separated _____Divorced _____ Widowed

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Alcohol Consumption: _____None _____Yes Occasional/Social # of drinks per day _______

Tobacco per day: None Yes #______Packs/day ______Cigarettes/day _____Smokeless Tobacco

If you previously stopped, When? ___________________________

Recreational Drugs: ______None If yes, please list:

____

Caffeinated beverages: None Low Moderate Excessive

PAST MEDICAL HISTORY

Please CHECK if you have or have had any of the following diseases or conditions:

- ☐ Anemia
- ☐ Angina
- ☐ Aortic Aneurysm
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bi-polar Disorder
- ☐ Bladder Cancer
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Brain Tumors
- ☐ Breast Cancer
- ☐ Bronchitis
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic lung disease
- ☐ Chronic renal failure
- ☐ Colitis
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated PSA
- ☐ Emphysema
- ☐ Enlarged heart
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herniated disc
- ☐ Hiatal hernia
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Infertility
- ☐ Kidney Infection
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Migraine
- ☐ Mitral Valve Prolapse
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Peptic ulcer
- ☐ Prostate cancer
- ☐ Pulmonary embolism
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Testicular Cancer
- ☐ Thyroid Disease

FAMILY HISTORY

Please CHECK which family member has/had any of the following

- ☐ **BLADDER CANCER** **Relationship:** ______________________________
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ **PROSTATE CANCER** **Relationship:** ______________________________
- ☐ Stroke

REVIEW OF SYSTEMS:

Please CHECK if you have or have had any of the following symptoms:

Constitutional

- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Fever
- ☐ Weakness
- ☐ Fatigue

Eyes

- ☐ Blurred vision
- ☐ Loss vision
- ☐ Vision Floaters
- ☐ Diminished Vision

Neurological

- ☐ Tingling
- ☐ Headache
- ☐ Dizziness
- ☐ Difficulty Walking
- ☐ Fainting
- ☐ Memory Loss

Psychological

- ☐ Anxiety
- ☐ Depression
- ☐ High Stress

Musculoskeletal

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Arm Pain
- ☐ Neck Pain
- ☐ Leg Pain
- ☐ Leg Cramps

Gastrointestinal

- ☐ Heartburn
- ☐ Difficulty Swallowing
- ☐ Nausea/vomiting
- ☐ Indigestion
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation

Cardiovascular

- ☐ Chest pain
- ☐ Varicose Veins
- ☐ Palpitations
- ☐ Sweating
- ☐ Swelling
- ☐ Fluttering Sensation

Skin

- ☐ Rash
- ☐ Bruising
- ☐ Wound
- ☐ Dry Skin

Ears, Nose, Throat

- ☐ Hearing Loss
- ☐ Dry Mouth
- ☐ Sore Throat
- ☐ Nasal Stuffiness

Respiratory

- ☐ Congestion
- ☐ Cough
- ☐ Shortness of breath

Genitourinary

- ☐ See HPI

Hematology

- ☐ Bleeds Easily
- ☐ Easily Bruising