

PATIENT HISTORY

Date: _____

Patient _____
Last First Middle

Date of Birth ____/____/____
Month Day Year

Street Address _____

Sex _____ Age _____

City _____ State _____ Zip _____

Home Phone _____

Occupation _____

Work Phone _____

Email _____ Referred By _____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Children _____ Ages _____

Present Complaints/Concerns (Symptoms, Duration)

1. _____

2. _____

3. _____

Known drug or other allergies (if none, write "None") _____

Surgical History (Please chronologically list all major and minor surgeries and approximate dates):

Serious Accidents and Falls

Have you ever had an auto accident, sports injury or fall? Yes No Date _____

Describe: _____

Health History

- | | | |
|--|------------------------------|-----------------------------|
| Are you currently on hormone therapy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you tired or easily fatigued? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have problems with memory loss? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have muscle cramps? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you feel you have a low sex drive? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have high Cholesterol? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Males

- | | | |
|--|------------------------------|-----------------------------|
| Do you have difficulty or pain when urinating? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you get up at night to urinate? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have a problem with slow urination? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have an elevated PSA? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do have any problems with your Prostate? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have problems with erectile dysfunction | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Females

Number of pregnancies _____ Number of live births _____ Age at first period: _____
 First day of last period: _____ Normal duration of menstrual period: _____ days
 History of irregular periods? Yes No Heavy bleeding? Yes No
 Do you experience significant menstrual cramping? Yes No
 Do you have a tendency toward premenstrual syndrome? Yes No
 Date of last Pap test: _____ History of Abnormal Pap tests? Yes No
 Do you have a family history of breast or ovarian cancer or osteoporosis? Yes No

Lifestyle Habits

Do you drink Coffee or Tea? Yes No
 Do you drink Soda Pop? Yes No
 Do you drink Alcohol? Yes No
 Do you use Tobacco? Yes No
 Do you use Recreational drugs? Yes No

Digestive Function

Do you have any food intolerances? Yes No
 Do you have any digestive problems? Yes No
 Do you ever have blood with bowel movements? Yes No
 Are your stools ever black or tarry? Yes No

Medical History: Check any diseases that you or your relatives have had.

Relatives	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Gout	Heart Disease/Stroke	High Blood Pressure	Hypothyroidism	Kidney Disease	Neurological Disease	Stomach Ulcer	Periodontal Disease	Tuberculosis	Atherosclerosis	Obesity	Senility
You																		
Father																		
Mother																		
Brothers																		
Sisters																		
Spouse																		
Children																		
Grandparents																		

Check any other illnesses you now have or have had:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hives | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Attempted Suicide | <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Malaria | <input type="checkbox"/> Skin Ulcers |
| <input type="checkbox"/> Benign Breast Tumor | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Measles | <input type="checkbox"/> Skipped Heart Beats |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gingivitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Candida Albicans | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Myopia | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Neuralgia | _____ |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Night Blindness | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hernia | <input type="checkbox"/> Numbness | |