



Name: \_\_\_\_\_  
Date: \_\_\_\_\_

## CHIEF COMPLAINT

What is the **main problem** that brings you to see us today?

## ALLERGIES

Are you allergic to any of the following? Please check **Yes** or **No** for each.

Check here if you have **NO** known allergies

Allergen	Yes	No	Reaction
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	
Latex	<input type="checkbox"/>	<input type="checkbox"/>	
IV Contrast Dye	<input type="checkbox"/>	<input type="checkbox"/>	
Cipro / Levaquin	<input type="checkbox"/>	<input type="checkbox"/>	
Macrobid / Nitrofurantion	<input type="checkbox"/>	<input type="checkbox"/>	
Others (please list):	<input type="checkbox"/>	<input type="checkbox"/>	



## MEDICATIONS

Please list the **name and dosage** of all medications you are taking (include regularly used over-the-counter medications/supplements). **IF YOU HAVE A MEDICATION LIST WITH YOU, PLEASE SUBMIT IT WITH THIS FORM.**

Check here if you are currently taking **NO** medications

Medication	Dose

## SURGICAL HISTORY

Have you ever had any of the following **surgeries or procedures**? Please check **Yes** or **No** for each.

Check here if you have had **NO** surgeries or procedures

Urogological Surgeries	Yes	No	Date
Kidney surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder or Incontinence surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Scrotal/Testicle surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Penis surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	



<b>Abdominal Surgeries</b>	<b>Yes</b>	<b>No</b>	<b>Date</b>
Appendix removal	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder removal (cholecystectomy)	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Groin (inguinal)?                      Side?	<input type="checkbox"/>	<input type="checkbox"/>	
Navel (umbilical)?	<input type="checkbox"/>	<input type="checkbox"/>	
Removal of bowel	<input type="checkbox"/>	<input type="checkbox"/>	
Bag for drainage of stool (ostomy)?	<input type="checkbox"/>	<input type="checkbox"/>	
Aneurysm repair	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Gynecological Surgeries</b>	<b>Yes</b>	<b>No</b>	<b>Date</b>
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
C-section	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Brain, Head or Neck Surgeries</b>	<b>Yes</b>	<b>No</b>	<b>Date</b>
Carotid surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Chest Surgeries</b>	<b>Yes</b>	<b>No</b>	<b>Date</b>
Heart bypass	<input type="checkbox"/>	<input type="checkbox"/>	
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Joint or Bone Surgeries</b>	<b>Yes</b>	<b>No</b>	<b>Date</b>
Artificial joint / replacement?                      Which one?	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Other Surgeries (Please List):</b>	<b>Date</b>



## PAST MEDICAL HISTORY

Have you ever been treated for any of the following **medical problems**? Please check **Yes** or **No** for each.

Condition	Yes	No
Adrenal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots / Bleeding Problems / Deep Vein Thrombosis / Pulmonary Embolus	<input type="checkbox"/>	<input type="checkbox"/>
Cancers (please list):	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack / Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Infections	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list):	<input type="checkbox"/>	<input type="checkbox"/>

## FAMILY HISTORY

Do you have **close relatives** with any of the following conditions or do any of the following conditions **run in your family**? Please check **Yes** or **No** for each.

Condition	Yes	No
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancers	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list):	<input type="checkbox"/>	<input type="checkbox"/>



## SOCIAL HISTORY

Please check or fill in the appropriate answer for each question.

Question	Answer
What is your marital status?	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Do you smoke?	<input type="checkbox"/> Yes, Daily <input type="checkbox"/> Yes, Not Daily <input type="checkbox"/> Not anymore <input type="checkbox"/> Never Smoked
How long have you smoked?	
How many packs per day?	
When did you quit?	
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> Not Anymore <input type="checkbox"/> Never Drank
How much do you drink per week?	
What do you drink?	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor
When did you quit?	
How many caffeinated beverages do you have per day?	
Have you ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your primary language?	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Italian <input type="checkbox"/> Other:
What is your race?	<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
What is your ethnicity?	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino
What do you do for a living (occupation)?	
Who is your employer?	



## REVIEW OF SYSTEMS

Do you have any problems related to the following? Please check **Yes** or **No** for each.

<b>Constitutional</b>	<b>Yes</b>	<b>No</b>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>

<b>Eyes</b>	<b>Yes</b>	<b>No</b>
Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>

<b>Ears, Nose, Mouth, Throat</b>	<b>Yes</b>	<b>No</b>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Stuffiness	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>

<b>Cardiovascular</b>	<b>Yes</b>	<b>No</b>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>

<b>Respiratory</b>	<b>Yes</b>	<b>No</b>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>

<b>Gastrointestinal</b>	<b>Yes</b>	<b>No</b>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Change in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>

<b>Musculoskeletal</b>	<b>Yes</b>	<b>No</b>
Chronic Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sore Muscles	<input type="checkbox"/>	<input type="checkbox"/>

<b>Integumentary, Skin</b>	<b>Yes</b>	<b>No</b>
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Itching	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer History	<input type="checkbox"/>	<input type="checkbox"/>

<b>Neurological</b>	<b>Yes</b>	<b>No</b>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>

<b>Hematologic, Lymphatic</b>	<b>Yes</b>	<b>No</b>
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>

<b>Endocrine</b>	<b>Yes</b>	<b>No</b>
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Chronically Too Hot / Cold	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>