

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History (please check all that apply)**

GERD/Heartburn  Congestive Heart Failure 

Ulcers  Atrial Fibrillation 

Colon Polyps  Pacemaker 

Irritable Bowel Syndrome  AICD(Defibrillator) 

Hernia  COPD 

Hemorrhoids  Diabetes 

Diverticulosis  Thyroid Problems 

Pancreatitis  Elevated Cholesterol 

Crohn’s Disease  Stroke 

Ulcerative Colitis  Fibromyalgia 

High Blood Pressure  Arthritis 

Coronary Artery Disease  Blood Transfusion 

Cardiac Stent  Cancer 

Kidney Failure  Dialysis 

Sleep Apnea  Heart Attack 

Cataracts  Glaucoma 

Measles  Mumps 

Rubella  Chickenpox 

Rheumatic Fever  Polio 

Depression  Anxiety 

**Men Only:** *(if applicable)* **Women Only:** *(if applicable)*

Date of last PSA (lab test) \_\_\_\_\_\_\_\_\_\_\_\_ Date of last menstrual cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last prostate exam/DRE \_\_\_\_\_\_\_\_\_\_\_\_ Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain or lump in testicles YES No Date of last DEXA Scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostate problems YES No Pelvic Pain YES No

Straining with urination YES No Abnormal vaginal bleeding YES No

Sexual Difficulties YES No Sexual difficulties YES No

Abnormal Pap Smear YES No

# of pregnancies\_\_\_ live births\_\_\_ miscarriages\_\_\_

**Please list all Specialists who are involved with your care:** (*If none skip to next* ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Surgical History Date/Year Date/Year**

Colonoscopy  \_\_\_\_\_\_\_ Breast Cancer Surgery  \_\_\_\_\_\_\_\_\_

EGD (Upper Endoscopy)  \_\_\_\_\_\_\_ Prostate Surgery  \_\_\_\_\_\_\_\_\_

Ulcer Surgery  \_\_\_\_\_\_\_ Back Surgery  \_\_\_\_\_\_\_\_\_

Colon Surgery  \_\_\_\_\_\_\_ Hip Surgery (R)(L)  \_\_\_\_\_\_\_\_\_

Gallbladder Surgery  \_\_\_\_\_\_\_ Knee Surgery (R)(L)  \_\_\_\_\_\_\_\_\_

Appendectomy  \_\_\_\_\_\_\_ Weight Loss Surgery  \_\_\_\_\_\_\_\_\_

Hemorrhoidectomy \_\_\_\_\_\_\_ Heart Bypass Surgery  \_\_\_\_\_\_\_\_\_

Heart Valve Replacement \_\_\_\_\_\_\_ Hysterectomy  \_\_\_\_\_\_\_\_\_

Ovaries Removed (R)(L)  \_\_\_\_\_\_\_ (partial/complete)

**Family History (Please CHECK ALL that apply for each family member)**

**Mother** Alive (Age:\_\_\_\_) Deceased (Age:\_\_\_\_\_) Unknown

Heart Attack Heart Disease Peripheral Vascular Disease

High Blood Pressure High Cholesterol Diabetes Stroke

Cancer If yes, what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Colon, Breast, etc)

**Father**  Alive (Age:\_\_\_\_) Deceased (Age:\_\_\_\_\_) Unknown

Heart Attack Heart Disease Peripheral Vascular Disease

High Blood Pressure High Cholesterol Diabetes Stroke

Cancer If yes, what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Colon, Prostate, etc)

**Other Relatives** Heart Attack Heart Disease Peripheral Vascular Disease

High Blood Pressure High Cholesterol Diabetes Stroke

Cancer If yes, what type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Colon, Breast, Prostate, etc)

**Social History (Please CHECK All that Apply)**

**Marital Status:** Married Single Divorced Widowed Life Partner

Legally Separated

**Occupation:** Full Time Part Time Retired Homemaker Student Unemployed Disabled

**Who Lives With You:** Spouse Children Partner Mother Father  No One Roommate

**Exercise:** Never Daily 1-2 times per week  3-4 times per week

**Diet:** Yes No Physician prescribed diet

**Caffeine Use:** None Daily 1-3 cups/drinks a day  4 + cups/drinks per day

**Tobacco Use:**

**Current tobacco user**

Form: Cigarettes Cigars Smokeless Tobacco

Amount: ½ PPD 1 PPD 2 PPD More than 2 PPD

Duration: 0-5 years 6-10 Years 10-20 years 20+ years

**Previous tobacco user**

Form: Cigarettes Cigars Smokeless Tobacco

Amount: ½ PPD 1 PPD 2 PPD More than 2 PPD

Duration: 0-5 years 6-10 Years 10-20 years 20+ years

If you quit, what year did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Never a tobacco user**

Are you exposed to “second-hand” smoke? YES No

**Alcohol Use:** Never Daily Social Drinker Trying to Quit  Previously

Less than 12 drinks a month 1-12 drinks a month

4-15 drinks a week more than 2 drinks a day

**Recreational Drug Use:** Never Daily Trying to Quit Previously

**Last Date of Immunizations (Please Mark All That Apply)**

Tetanus (within last 10 years) Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Measles Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Influenza Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mumps Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rubella Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles Date:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Polio Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis A (2 shot series) Date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis B (3 shot series) Date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ALL PRESCRIBED DRUGS AND OVER THE COUNTER DRUGS SUCH AS VITAMINS AND INHALERS**

**Name of Medication Strength Frequency Taken Prescribed By: Refills Needed (Yes/No)**

(*ex: ) Medication ABC \_\_\_\_5mg 1 capsule once a day in the morning Dr. ABC* YES No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES No

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**PLEASE LIST ALL ALLERGIES INCLUDING MEDICATIONS THAT YOU ARE ALLERGIC TO**

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