C O N F I D E N T I A L

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Name		Age	Date of Birth	Today's Date
Marital status?	☐ Married ☐ Widower ☐ Divorced ☐ Single ☐ Separated ☐ Live with partner	Spouse/partner's name	I prefer to be addressed as (e.g., Rosie, Rose, Rose Marie, Mrs. Jones):	

CHIEF COMPLAINT
Briefly describe the main medical problem(s) you have **today**

FAMILY HISTORY List all immediate family members. List all known medical problems of each (including cause of death if appropriate). Be sure to include:

Diabetes	Heart disease	Heart attack	High blood pressure
Asthma	Colon polyps	Allergies	Bleeding tendencies
Anemia	Glaucoma	Emphysema	Lung disorder
Stroke	Hardening of the arteries	Deafness	Tuberculosis
Hepatitis	HIV/Aids	Genetic disorders	Birth defects
Cancer (list type)	Leukemia	Depression	Mental disorders
Epilepsy or seizures	Muscle disorders	Migraine headaches	Kidney disease

	Name	Full	Half	Living? Yes or No	Age now or at time of death	Medical problems (including cause of death if appropriate)
Mother						
Father						
Brothers and Sisters (✓full or half)						
Children						

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OCCUPATIONAL/EDUCATIONAL HISTORY

What type of work do you do?		Employer's name	
Have you worked extensively...		years		years
	at a coal mine?		with asbestos?	
	in a quarry?		with sand blasting?	
	in a farm silo?		with birds?	
	with toxic chemicals?		with radioactive materials?	

Have you served in the military?	Branch	Years of service	Warfare specialty	Do you also go to the VA clinic?

Education level achieved?

HEALTH RISK ASSESSMENT

Use of tobacco:	Cigarettes ☐	Age started _____	Packs/amount per day: _____	Are you ready to quit? ☐ Yes ☐ No	What methods have you used to quit?
☐ Never used it ☐ Used to but quit ☐ Still use it	Cigars ☐ Pipe ☐ Snuff/chew ☐	Age stopped _____			

What describes your use of alcoholic beverages? (may choose more than one)			
	☐ Never a drinker	☐ 3 or more drinks daily	☐ Alcoholic
	☐ 1 – 5 drinks per year	☐ Drink heavy on weekends only	☐ Recovered alcoholic
	☐ 1 – 2 drinks per month	☐ Heavy drinker all week	Sobriety date _____
	☐ 1 – 2 drinks weekly	☐ One/both of my parents are alcoholics	I attend AA ☐ yes ☐ no
	☐ 1 – 2 drinks daily	☐ I need help	

What describes your illegal drug use history? (may choose more than one)			
	☐ Never used drugs	☐ I use other drugs _____	☐ I have used IV drugs in the past
	☐ I use marijuana	☐ I use intravenous drugs	☐ I used to use drugs but quit
	☐ I use methamphetamine	☐ I have shared needles in the past	Date of last drug use _____
	☐ I use cocaine	☐ I need help	I attend NA ☐ yes ☐ no

How much do you exercise per week?

Do you know your cholesterol levels?	☐ No	☐ Yes Total cholesterol _____ HDL _____ LDL _____ Triglicerides _____ Date _____
I wear my seat belt and shoulder harness?	☐ Always ☐ Never ☐ Sometimes ☐ Only on long drives	

IMMUNIZATION HISTORY

CHICKEN POX	I had ☐ Chicken pox ☐ Shingles ☐ I had the chicken pox vaccine _____ years ago.
TETANUS	☐ My last tetanus shot was _____ years ago. ☐ I have never had a tetanus shot.
FLU	☐ I get flu shots every year. ☐ I do not get flu shots because:
PNEUMONIA	☐ I had a pneumonia shot _____ years ago. ☐ I have never had a pneumonia shot.
HEPATITIS A	☐ I had hepatitis A in _____. ☐ I had hepatitis A shots. ☐ I have never had hepatitis A or the shots to prevent it.
HEPATITIS B	☐ I had hepatitis B in _____. ☐ I had hepatitis B shots in _____. ☐ I have never had hepatitis B or the shots to prevent it.
MEASLES	☐ I was born before 1957 (no booster needed). ☐ I had a booster shot in _____. (Measles alone or MMR booster) ☐ I was born after 1956 and I have never had a booster shot.

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CHRONIC DISEASES List all of your known chronic medical conditions or diseases

Disease or condition	Age at diagnosis	Current status	If you see a specialist, who do you see?

SURGERIES List all of your major surgeries

Type of surgery	Where done	Age or year	Surgeon's name

HOSPITALIZATIONS List all major hospitalizations other than for your chronic diseases/conditions or for surgeries listed above

Reason for hospitalization	Age or year	Treating physician/hospital

COLON CANCER SCREENING

Do you have a parent, sibling, or child with a history of colon cancer or colon polyps? ☐ Yes ☐ No	If yes, who?	Have you had your colon screened for cancer by sigmoidoscopy or colonoscopy? ☐ Yes ☐ No	If yes, when and by which doctor?

ALLERGIES List all drug, food, or other allergies you have

Drugs you are allergic to or make you sick	What happens if you take it?	Foods you are allergic to	Other things you are allergic to

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PROSTATE HISTORY If under age 40 skip to next section.

INTERNATIONAL PROSTATE SYMPTOM SCORE Circle the one best answer.	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
1. **Incomplete emptying.** *Over the past month*, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. **Frequency.** *Over the past month*, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. **Intermittency.** *Over the past month*, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. **Urgency.** *Over the past month*, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. **Weak stream.** *Over the past month*, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. **Straining.** *Over the past month*, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 or more times	
7. **Nocturia.** *On a typical night* how many times do you get up to urinate from the time you to bed until the time you got up in the morning?	0	1	2	3	4	5	
	Delighted	Pleased	Mostly satisfied	Equally satisfied & dissatisfied	Mostly dissatisfied	Unhappy	Terrible
Quality of life due to urinary symptoms. If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

CURRENT MEDICATIONS List all current medications, *including over the counter medicines and vitamins/supplements.*

Medications taken on a regular schedule:

Name of medication	Dose (mgs)	How taken (times per day, with food, at bedtime, etc.)

Medications taken only *as needed:*

Medication	Dose (mgs)	Reason for use	How often actually used

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REVIEW OF SYSTEMS Check all of the following symptoms that you **now have:**

GENERAL/ CONSTITUTIONAL	☐ fever ☐ excessive fatigue	☐ unintended weight loss	☐ unintended weight gain	☐ severe night sweats ☐ other _____
SKIN	☐ itching ☐ hives ☐ corns ☐ growth you want removed	☐ burning ☐ fungus ☐ ingrown nail ☐ discolored/irregular mole	☐ mole you want removed ☐ warts ☐ skin tumor/growth ☐ mole that has changed	☐ acne ☐ chronic skin problem ☐ sores ☐ other _____
EAR	☐ hearing loss ☐ pain	☐ recurrent ear aches/infections ☐ drainage	☐ noises in the ear	☐ motion sickness ☐ other _____
NOSE	☐ sinus pain or pressure ☐ recurrent sinus infections	☐ nose bleeds	☐ loss of smell	☐ chronic nasal drainage ☐ other _____
MOUTH/THROAT	☐ sore tongue ☐ recurrent sore throat ☐ cavities	☐ bleeding gums ☐ recurrent mouth ulcers ☐ tooth pain	☐ hoarseness ☐ thrush/white patches ☐ recurrent strept throat	☐ wear dentures ☐ peculiar taste ☐ other _____
EYES	☐ wear glasses/contacts ☐ colored halos around lights ☐ excessive tearing ☐ color blind	☐ blurry vision ☐ blind spots ☐ cataracts ☐ drainage	☐ double vision ☐ burning ☐ dryness	☐ glaucoma ☐ redness ☐ night blindness ☐ other _____
HEART/CIRCULATION	☐ chest pain ☐ heart attack in past ☐ legs/arms get cold ☐ spider veins ☐ short of breath if lying down ☐ rheumatic fever	☐ high blood pressure ☐ palpitations/heart pounding ☐ loss of hair on legs ☐ fingers turn blue, white or red ☐ need to take antibiotics before dental procedures	☐ swelling in feet or ankles ☐ irregular heart beat ☐ legs hurt after walking ☐ wake up short of breath at night	☐ heart murmur ☐ poor circulation ☐ varicose veins ☐ ulcers or sores on legs ☐ blood clots in past ☐ other _____
LUNGS	☐ chronic cough ☐ always short of breath ☐ asthma	☐ wheezing ☐ short of breath when climbing stairs	☐ cough up blood ☐ short of breath with mild exercise	☐ cough up sputum/phlegm ☐ use home oxygen ☐ other _____
DIGESTIVE	☐ loss of appetite ☐ bloating ☐ vomiting blood ☐ trouble swallowing	☐ nausea ☐ liver disease ☐ hemorrhoids/piles ☐ pancreatitis	☐ vomiting ☐ ulcers ☐ abdominal pain ☐ blood, mucous, puss in stools	☐ diarrhea ☐ gall bladder problems ☐ change in bowel habits ☐ constipation ☐ other _____
URINARY	☐ frequent nighttime urination ☐ bed wetting	☐ inability to hold urine ☐ leak urine	☐ pain/burning with urination ☐ urine/bladder/kidney infection	☐ difficulty starting urination ☐ other _____
BREAST	☐ lumps in breast	☐ painful breast	☐ drainage from nipple	☐ other _____
SEXUAL	☐ lack of interest/low sex drive ☐ sexually transmitted disease	☐ partner may have sexually transmitted disease	☐ partner lack of interest/drive ☐ unable to reach orgasm	☐ other _____
NERVOUS	☐ seizures/convulsions ☐ temporary blindness ☐ paralysis	☐ numbness ☐ weakness of extremity ☐ polio	☐ fainting spells ☐ dizzy spells ☐ meningitis	☐ severe headaches ☐ stroke ☐ other _____
MUSCULOSKELETAL	☐ painful joints ☐ arthritis	☐ muscle pain ☐ carpal tunnel syndrome	☐ swollen joints ☐ back pain	☐ gout ☐ other _____
GLANDS	☐ very sensitive to temperature changes ☐ excessive fluid intake	☐ hair loss ☐ thinning/coarsening of hair	☐ thyroid disorder ☐ frequent urination	☐ diabetes ☐ constantly thirsty ☐ other _____
MENTAL	☐ depressed ☐ suicidal thoughts ☐ unable to concentrate	☐ excessive worry ☐ hear voices ☐ cry too much	☐ excessive anger ☐ memory problems ☐ unhappy	☐ sleep problems ☐ sleep too much ☐ other _____

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REVIEW OF SYSTEMS (continued) Check all of the following symptoms that you **now have:**

BLOOD/LYMPH	☐ anemia	☐ swollen lymph nodes	☐ bleed easily	☐ easy bruising ☐ other _____
ALLERGY/IMMUNITY	☐ hay fever	☐ allergies	☐ immune deficiency	☐ HIV/AIDS ☐ other _____

SEXUAL HISTORY My sexual status is: ☐ Heterosexual ☐ Bisexual ☐ Homosexual	☐ Virgin ☐ Sexually active in past but not for_____yrs ☐ Sexually active now	If sexually active now: ☐ long-term monogamous situation ☐ 2 - 5 partners in last year ☐ 6 - 10 partners in last year ☐ more than 10 partners in last year	If not in long-term monogamous situation: ☐ Always use condoms ☐ Sometimes use condoms ☐ Never use condoms	Blood tests for HIV, Hepatitis B, and Hepatitis C: ☐ I have been tested ☐ I want to be tested ☐ My partner has been tested ☐ I want my partner tested

SEXUAL PERFORMANCE	☐ I am satisfied with my situation ☐ I am not satisfied with my situation	If not satisfied, what is the problem?	☐ Never can get an erection ☐ Sometimes cannot get an erection ☐ Other

SOCIAL HISTORY

Who was your previous family physician?	Who else lives in your household?	If the patient was unable to complete this form, who filled it out?

DIET HISTORY

I am on the following special diet:

ADVANCED DIRECTIVES

Do you have a living will? ☐ Yes ☐ No	Have you legally appointed a **healthcare representative** to make medical decisions in the event you are incapacitated and unable to make decisions for yourself? ☐ Yes ☐ No	If yes, who is your healthcare representative?	Do you want to be an organ donor? ☐ Yes ☐ No

REVIEWED BY PHYSICIAN

Signature of doctor	Date	Signature of doctor	Date	Signature of doctor	Date