

Name _____ SS# _____ Date _____
 Address _____ Occupation _____
 Phone (home) _____ (work) _____ Date of birth _____ Age _____
 Chief complaint _____

DRUG ALLERGIES

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDS

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Bowel irregularity | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Chronic rashes |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Overactive bladder | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Sexual/menstrual dysfunction | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> GI disorder | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Nervousness | |

Do you have frequent, sudden urges to urinate?
 Yes No

How often do you urinate during the day?
 _____ times

How often do you wake up at night to urinate?
 _____ times

Do you experience wetting or leaking accidents?
 Yes No

MEN ONLY: It's common for men to occasionally experience erection problems. Is this something that happens to you?
 Yes No

How often does this occur?
 Frequently Sometimes Rarely