MEDICAL HISTORY

**Patient Name Male Female Today’s Date:**

**Age Date of Birth Height Weight Referring Dr.**

|  |  |
| --- | --- |
| **DO NOT FILL OUT SHADED AREA (FOR PHYSICIANS USE ONLY)** | |
| **CC:** | |
| **HPI:**  **Location:** Abdomen Flank Other | **Duration:** 30 minutes 1 hour Always there  Other |
| **Symptom Score: Onset:** 2 days ago 2 weeks ago 1 month ago Other | **Concurrent Symptoms:** YES NO Nausea Rash Headaches  Other |
| **Modifiers:** Moving around Standing up Lying on my side  Other | **Character:** Dull then Sharp Very Sharp then Leaves  Always there Other |

**SPECIFIC GENITO-URINARY SYMPTOMS OR COMPLAINTS: (PLEASE CIRCLE YES OR NO)**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Burning with urination Frequent urination Bladder pain  Urinary infections Blood in urine Difficulty voiding Incomplete emptying  Difficulty with erections | YES YES YES YES YES YES YES YES | | NO NO NO NO NO NO NO NO | Get up at night to void Loss of urinary control Kidney stones  Pain with urination Urgency to void Pelvic pain  Urethral discharge | YES YES YES YES YES YES YES | NO NO NO NO NO NO NO | Passing air in urine Slow urinary stream Stream starts and stops Straining to void  Bed wetting  Previous prostate trouble  Infertility | | YES YES YES YES YES YES YES | NO NO NO NO NO NO NO | |
| **REVIEW OF SYSTEMS: Do you now or have you had any problems related to the following systems? Circle YES or NO.** | | | | | | | | | | | |
| **Constitutional Symptoms** |  | |  | **Gastrointestinal** |  |  | **Genitourinary** | |  |  |  |
| Fever | Y | | N | Abdominal pain | Y | N | Urine retention | |  | Y | N |
| Chills | Y | | N | Nausea/vomiting | Y | N | Painful urination | |  | Y | N |
| Headache | Y | | N | Indigestion/heartburn | Y | N | Urinary frequency | |  | Y | N |
| Other | | |  | Other | |  | Other | | | | |
| **Eves** | | |  | **Cardiovascular** | |  | **Respiratory** | | | | |
| Blurred vision | Y | | N | Chest pain | Y | N | Wheezing | |  | Y | N |
| Double vision | Y | | N | Varicose veins | Y | N | Frequent cough | |  | Y | N |
| Pain | Y | | N | High blood pressure | Y | N | Shortness of breath | |  | Y | N |
| Other | | |  | Other | |  | Other | | | | |
| **Allergic/Immunologic** | | |  | **Gynecologic** | |  | **Ear/Nose/Throat/Mouth** | | | | |
| Hay Fever | Y | N | Irregular periods | Y | N | Ear infection | |  | Y | N |  |
| Drug allergies | Y | N | Post menopausal | Y | N | Sore throat | |  | Y | N |  |
| Other |  |  | Abnormal bleeding | Y | N | Sinus problems | |  | Y | N |  |
| **Neurological** |  |  | Other | |  | Other | | |  |  |  |
| Tremors | Y | N | **Hematologic/Lymphatic** | |  | **Musculoskeletal** | | |  |  |  |
| Dizzy spells | Y | N | Swollen glands Y | | N | Joint pain | | | Y | N |  |
| Numbness/tingling | Y | N | Blood clotting problem Y | | N | Neck pain | | | Y | N |  |
| Other |  |  | Other | |  | Back pain | | | Y | N |  |
| **Endocrine** |  |  | **Pschological** | |  | Other | | |  |  |  |
| Excessive thirst |  | Y | N | Are you generally satisfied with your life? | | | Y | N | | | |
| Too hot/cold |  | Y | N | Do you feel severely depressed? | | | Y | N | | | |
| Tired/sluggish |  | Y | N | Have you ever considered suicide? | | | Y | N | | | |
| Other |  |  |  | Other | | |  |  | | | |
| MedHx1 | | | | | | | | | | | |

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**PAST SURGICAL HISTORY General Surgery**

 Appendix

 Abdominal Hernia

 Bowel

 Gall Bladder

 Groin Hernia

 Hemorrhoid

 Incisional Surgery

 Spleen

 Stomach

 Tonsil & Adenoid

**Lung Surgery**

 Benign

 Cancer

**Heart Surgery**

 Valve

 Bypass Graft

 Vascular Surgery

**Urologic Surgery**

 Trim of Prostate Gland

 Urethral Stricture

 Testicular Surgery

 Vasectomy

 Testicular Removal

 Circumcision

 Removal of Penile Lesion

 Penile Lesion

**Female Surgery**

 Uterus

 Ovaries

 Other

**Other Surgery**

 Eye Surgery

 Glaucoma

 Ear Surgery

 Nose Surgery

**Kidney Surgery**

 Open Removal of Stone

 Partial Removal of Kidney

 Entire Removal of Kidney

**Orthopaedic Surgery**

 Back Surgery

 Artificial Hip/Knee

 Disc Surgery

 Knee Surgery

**Bladder Surgery**

 Lifting of Bladder

 Abdominal/Vaginal

 Partial Removal of Bladder

 Removal of Bladder Stone

 Removal of Bladder Tumor

 Entire Removal of Bladder

**List Serious Illnesses of Hospitalizations: (Example: Diabetes, Tuberculosis, Breast Cancer, Heart Disease, Bleeding Disorder, Stroke, Emphysema, Hepatitis, Diverticulitis, etc.)**

**GYNECOLOGICAL HISTORY**

# Pregnancies # Children # Miscarriages Last Pap Smear\_ Last Menstrual Period

**MEDICATIONS: (Include dose and schedule) DRUG ALLERGIES:**

**FAMILY & SOCIAL HISTORY:**

Marital History (circle one): Married Divorced Single Widowed

Parents (List age and any major health problems if living. List age and cause of death if deaceased.):

Mother Father

CIRCLE ANY of the following diseases that “run” in your family: Diabetes Heart Disease Stroke Hypertension Kidney Trouble Kidney Stones Cancer (what kind?) Prostate Cancer Other

**Habits:**

|  |  |  |  |
| --- | --- | --- | --- |
| Cigarette smoking | Y | N | # packs/day How many years? |
| Tobacco chewing/snuff  Alcoholic beverages | Y  Y | N  N | How many years? |

Occupation:

**Physician: Date:**

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