PATIENT NAME: _____ DATE: ___/___/_____ MED REC #:_____

DATE OF BIRTH: ___/___/_____ AGE: _____ HEIGHT: _____FT _____IN WEIGHT: _____LBS

Referring Physician: _____ Referring Physician's Phone #:_____ Referring Physician's Address: _____

Primary Care Physician (if Different)_____ Phone #:_____

Race ☐ White ☐ Black ☐ Hispanic / Latin ☐ Asian Other: _____ Sex: ☐ Female ☐ Male

Marital/Family Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Previously widowed? ☐ Yes ☐ No Previous divorce? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No If so, number:_____

Reason for your visit today: _____

Pharmacy Name: _____ Address: _____ City:_____ Zip:_____

Pharmacy Phone #:_____ Pharmacy Fax #: _____

Drug Allergies: _____ Reaction: _____

Other Allergies: _____ Reaction: _____

Medical History

	Yes	No
Angina (chest pain related to heart disease)	☐	☐
Anxiety	☐	☐
Arteriosclerosis (Hardening of the Arteries)	☐	☐
Arthritic Joints	☐	☐
Asthma	☐	☐
COPD	☐	☐
Depression	☐	☐
Deep Vein Thrombosis	☐	☐
Diabetes	☐	☐
Elevated Cholesterol	☐	☐
Gout	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
If yes, do you take antibiotics for dental procedures?	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HIV	☐	☐
Hypothyroid (Low Thyroid)	☐	☐
Kidney Stones	☐	☐
Pacemaker Placement	☐	☐
Parkinson's Disease	☐	☐
Pulmonary Emboli (Blood Clot in Lung)	☐	☐
Sickle Cell Trait/Disease	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Use of Coumadin	☐	☐
Valvular Heart Disease	☐	☐
Weight Loss	☐	☐

Other:

_____

_____

Medications: (continue on reverse side if more space is needed)

Name	Strength	Frequency
Daily use of aspirin? ☐ Yes ☐ No		

Family History

FAMILY HISTORY of kidney stones? ☐ Yes ☐ No

FEMALES ONLY

pregnancies _____ # children _____

Date of Last Menstrual Period? _____

Date of Last PAP Smear? _____

☐ Normal ☐ Abnormal

MALES ONLY

History of Prostate Infections ☐ Yes ☐ No

Family History of Prostate Cancer? ☐ Yes ☐ No

Date of your last prostate exam? _____

Date of your last PSA test? _____

Surgical History: (continue on reverse side if more space is needed)

Year	Operation	Hospital

Social History

Do you or have you smoked Cigarettes?
☐ Yes ☐ No ☐ Quit (Year_____) # packs per day?___

Do you or have you used alcohol?
☐ Yes ☐ No ☐ Quit (Year_____) # drinks per week? ___

Substance Abuse ☐ Yes ☐ No ☐ Quit (Year_____)

Coffee	Cups Per Day	0	1	2	3	4+
Tea	Cups Per Day	0	1	2	3	4+
Carbonated Drinks	Cans Per Day	0	1	2	3	4+
Water	Cups Per Day	0	1	2	3	4+

Exercise Activity:_____

Occupation:_____

Over the past month, how often have you:	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
1 had a sensation of not emptying your bladder completely after urinating?	0	1	2	3	4	5
2 had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3 found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4 found it difficult to postpone urination?	0	1	2	3	4	5
5 had a weak urinary stream?	0	1	2	3	4	5
6 had to push or strain to begin urination?	0	1	2	3	4	5
7 most typically gotten up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	(number of times) 3	4	5

Total score _____

PATIENT REVIEW OF SYSTEMS: Please mark all yes or no

Constitutional--☐Neg

	Yes	No
chills	○	○
fever	○	○

Respiratory--☐Neg

	Yes	No
dyspnea (shortness of breath)	○	○

Gastrointestinal-☐Neg

	Yes	No
diarrhea	○	○

Metabolic/Endocrine--☐Neg

	Yes	No
goiter	○	○

Musculoskeletal-☐Neg

	Yes	No
back pain	○	○

Heent---☐Neg

	Yes	No
double vision	○	○

Cardiovascular--☐Neg

	Yes	No
chest pain	○	○

Integumentary--☐Neg

	Yes	No
rash	○	○

Neurological--☐Neg

	Yes	No
syncope/fainting	○	○

Hema/Lymphatic-☐Neg

	Yes	No
easy bleeding	○	○
petechiae/easy bruising	○	○

Psychiatric--☐Neg

	Yes	No
anxiety	○	○

Additional Information / Medications / Surgical History

_____

_____

_____

_____

11 System ROS

☐ All Negative

FOR DOCTORS ONLY:

CHIEF COMPLAINT

PRESENT ILLNESS

PHYSICAL EXAM

PROCEDURES

LAB

OUTSIDE RECORDS

ASSESSMENT

PLAN