Please Fill Out Completely

Date:_____

Home Phone # _____
Cell Phone # _____
Work Phone # _____
e-mail:_____

Date of Birth:_____Age:_____Marital Status: M S D W Sex: Male Female

Patient Last Name:_____First:_____Middle:_____

Address:_____City:_____State_____ZIP_____

Patient Employer_____Occupation:_____

Spouse Name_____ Ok to release Medical Information spouse? ☐ YES ☐ NO

Spouse Employer or School if Child_____Job Title_____Phone_____
*Applies only to parents of minor children or children insured under the parents insurance

*Parent Name:_____ *Parent Name:_____

Referring Doctor:_____Phone:_____
Primary Care Doctor_____ Phone:_____

Pharmacy Name / Location_____Phone:_____

Emergency Contact_____Phone:_____

Race: ☐ Caucasian □ African American □ Hispanic □ Asian/Indian/Pakastani/Sri Lankan □ Chamorran □ Chinese □ Fiji Islander □ Fillipino □ Guananian NOS □ Hawaiian □ Hmong □ Japanese □ Kampuchean/Cambodian □ Korean □ Laotian □ Melanesian NOS □ Micronesian NOS □ Samoan □ Tahitian □ Thai □ Tongan □ Vietnamese □ Other_____

RESPONSIBLE PARTY INFORMATION

Primary Insurance_____

Name of Insured:_____
Date of Birth of Insured:_____

Policy #_____Group #_____
Insurance Address_____
Customer Service Phone Number_____

Secondary Insurance_____

Name of Insured:_____
Date of Birth of Insured:_____

Policy #_____Group #_____
Insurance Address_____
Customer Service Phone Number_____

Signature of Patient

X_____

Signature of Responsible Party

X_____

Patient Name:_____**Age:**_____**Date:**_____

REASON FOR YOUR VISIT TODAY:_____

_____

Have you or do you have any of the following: Check / Circle all that applies to you

☐ Heart Disease ☐ High Blood Pressure ☐ Heart attack ☐ Aneurysm ☐ Mitral valve prolapse ☐ Blood Clots in legs ☐ Stroke ☐ Diabetes Date Diagnosed:_____ ☐ Hyperthyroidism **or** Hypothyroidism ☐ Stomach Ulcers ☐ Hepatitis A B Or C ☐ Hemorrhoids ☐ Hernia ☐ Liver disease	☐ Urinary Infections ☐ Prostatitis ☐ Kidney disease ☐ Emphysema / Bronchitis ☐ Lung Disease ☐ Asthma ☐ Glaucoma Open or Closed ☐ Hearing loss ☐ Depression ☐ Cancer_____

Previous Surgery / Hospitalization (LIST ALL) _____

_____

Medications: (INCLUDE OVER THE COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS)_____

_____

DRUG ALLERGIES:_____

FEMALE PATIENTS ONLY

Are you or could you be pregnant? Yes / No # of pregnancies:_____

Date of Last Menstrual Period:_____Type of Birth Control_____

FAMILY HISTORY

Do any of the following medical problems run in your family?

☐ Prostate Cancer ☐ Heart Disease ☐ Arthritis ☐ Stroke	☐ Diabetes ☐ High Blood Pressure ☐ Cancer Type:_____

Patient Name:_____**Age:**_____**Date:**_____

SOCIAL HISTORY

Exercise: Yes / No Alcohol: Yes / No Amount:_____ Caffeine: Amount per day_____

Tobacco Usage Yes / No # of Years_____, Quit _____

Employment:_____Occupation:_____

UROLOGICAL HISTORY:

(PLEASE CHECK ALL THAT APPLY)

☐ Urological Surgeries / Problems, Please List _____
_____

☐ Any pain or burning when voiding / urinating?
☐ Any urgency or need to run to the bathroom?
☐ Any Urinary frequency or need to void many times during the night?
☐ Any sense of incomplete emptying of your bladder?
☐ Any leakage of urine?
☐ Any blood in urine?
☐ Any pain? If yes, where is your pain located?_____

DO NOT WRITE BELOW THIS LINE

_____/_____

(FOR PHYSICIAN USE ONLY) **VITALS: T BP P R WT**

Name:_____**Age:**_____**Date:**_____

REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT YOU CURRENTLY HAVE

CONSTITUTIONAL
- ☐ FEVER
- ☐ CHILLS
- ☐ WEIGHT CHANGE

EYES
- ☐ BLINDNESS
- ☐ DOUBLE VISION
- ☐ BLURRED VISION
- ☐ BURNING
- ☐ GLAUCOMA OPEN / CLOSED

IMMUNOLOGICAL
- ☐ FOOD SENSITIVITY
- ☐ ASTHMA
- ☐ RECENT VACCINATIONS

NEUROLOGICAL
- ☐ TREMORS
- ☐ DIZZINESS
- ☐ HEADACHES
- ☐ SEIZURES
- ☐ NUMBNESS / TINGLING

ENDOCRINE
- ☐ HEAT / COLD INTOLERANCE
- ☐ INCREASED THIRST
- ☐ FREQUENT URINATION
- ☐ HAIR LOSS
- ☐ TIRED / SLUGGISH

GASTROINTESTINAL
- ☐ ABDOMINAL PAIN
- ☐ DIARRHEA
- ☐ NAUSEA / VOMITING
- ☐ CONSTIPATION
- ☐ INDIGESTION / HEARTBURN
- ☐ BLOATING

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ IRREGULAR HEART BEAT
- ☐ ANKLE SWELLING
- ☐ HEART FAILURE

MUSCULOSKELETAL
- ☐ MULTIPLE JOINT SWELLING
- ☐ GOUT
- ☐ MULTIPLE FRACTURE
- ☐ NIGHT CRAMPS
- ☐ NECK PAIN
- ☐ BACK PAIN

EAR, NOSE, THROAT
- ☐ RINGING IN THE EARS
- ☐ HEARING LOSS
- ☐ HOARSENESS
- ☐ SORE THROAT
- ☐ RECURRENT NOSE BLEEDS
- ☐ MOUTH ULCERS
- ☐ EAR INFECTION

URINARY
- ☐ PAINFUL URINATION
- ☐ URINARY FREQUENCY
- ☐ BLOOD IN URINE
- ☐ LOSS OF BLADDER CONTROL
- ☐ URINARY DISCHARGE

RESPIRATORY
- ☐ COUGH
- ☐ SHORTNESS OF BREATH
- ☐ COUGH WITH BLOOD
- ☐ WHEEZING

HEMATOLOGIC
- ☐ SPONTANEOUS BLEEDING
- ☐ BRUISING
- ☐ ENLARGED LYMPH NODES
- ☐ ANEMIA
- ☐ JAUNDICE

PSYCHOLOGICAL

ARE YOU GENERALLY SATISFIED WITH YOUR LIFE?
☐ YES ☐ NO

DO YOU FEEL SEVERLY DEPRESSED?
☐ YES ☐ NO

HAVE YOU EVER CONSIDERED SUICIDE?
☐ YES ☐ NO