

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**UROLOGIC HISTORY**

Blood in urine?  Y  N  
 Pain or discomfort on urination?  Y  N  
 Do you have a problem with loss of urine?  Y  N

**If Yes:**  
 Urine loss with activity (sneezing,coughing)?  Y  N  
 Urgency right before you loose urine?  Y  N  
 Incontinent episodes per day? \_\_\_\_\_  
 Do you use pads?  Y  N  
 # per day \_\_\_\_\_ # per night \_\_\_\_\_ Type \_\_\_\_\_  
 Feeling of incomplete emptying?  Y  N

**REVIEW OF SYSTEMS** Are you experiencing?

Unexplained fevers/sweats  Y  N  
 Unexplained weight loss/gain  Y  N  
 Vision changes  Y  N  
 Ear/Nose/Mouth/Throat proble  Y  N  
 High blood pressure  Y  N  
 High cholesterol  Y  N  
 Swelling in legs  Y  N  
 Heart murmur  Y  N  
 Heart disease  Y  N  
 Astha/wheezing  Y  N  
 Tuberculosis/other  Y  N  
 Change in bowel habits  Y  N  
 Bloody stool  Y  N  
 Stomach ulcers  Y  N  
 Hepatitis/liver disease  Y  N  
 Kidney stones  Y  N  
 Any changes in moles/freckles  Y  N  
 Migraine headaches  Y  N  
 Depression/Anxiety  Y  N  
 Heat or cold intolerance  Y  N  
 Abnormal thirst  Y  N  
 Hot flashes  Y  N  
 Thyroid problems  Y  N  
 Cuts that don't stop bedding  Y  N  
 Blood clots in veins  Y  N  
 Blood transfusion?  Y  N  
 Objection to blood transfusion  Y  N

**SURGICAL HISTORY**

Date	Procedure	Surgeon

**HAVE YOU EVER BEEN HOSPITALIZED?**

Medical condition	Date	Name of Hospital

**MEDICATIONS** (include OTC medicine, vitamins & supplements)

Drug	Dosage	Prescribed By	For what condition

**ALLERGIES** (include type of reaction)

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**FAMILY HISTORY**

Have any of your close relatives had the following \_\_\_\_\_ Your relationship \_\_\_\_\_

Breast cancer  Y  N

Y  N Did the breast cancer develop before menopause?  
 Y  N Have you had two or more close relatives with breast or ovarian cancer? (sister, mom, grandma, aunt, half-sister)?  
 Y  N Do you have any family history of both breast/ovarian cancer?  
 Y  N Do you have one or more relatives who have had two cancers - two separate breast cancers or breast & ovarian cancer?  
 Y  N Do you have any male relatives with breast cancer?  Y  N Family history of diabetes  
 Y  N Family history of uterine cancer?  Y  N Family history of osteroparosis  
 Y  N Family history of colon cancer  Y  N Family history of heart attack/stroke  
 Y  N Family history of blood clots in legs/lungs

CURRENT AGE	LIST ANY MEDICAL PROBLEMS
Father _____	_____
Mother _____	_____
Sibling _____	_____
Sibling _____	_____
Sibling _____	_____

**SOCIAL HISTORY (SH)**

Your occupation: \_\_\_\_\_ Marital status:  Single  Married  Widows  Divorced  Domestic Partner

Do you smoke? (# cigs a day) \_\_\_\_\_ Anemia test When: \_\_\_\_\_ When: \_\_\_\_\_  
 Prior smoking? Amt \_\_\_\_\_ Quit Date \_\_\_\_\_ Thyroid test When: \_\_\_\_\_ When: \_\_\_\_\_  
 Drink alcohol? (glasses/week)? \_\_\_\_\_

Ever use street drugs? What/When \_\_\_\_\_

**IMMUNIZATIONS (date of last)**

Eat 6 servings of dairy products a day or  Y  N Tetanus  Y  N  
 Take 1000 mg calcium supplement?  Y  N Rubella  Y  N  
 Perform aerobic exercise 3x per week?  Y  N Hepatitis B  Y  N Did you receive 3 shots?  Y  N  
 Always wear your seatbelt? Bike helmet?  Y  N Have you ever had chicken pox?  Y  N  
 Ever had a colonoscopy?  Y  N When \_\_\_\_\_ Encouraged with PCP if > 10 years ago  
 Bone density scan (Dexa)  Y  N When \_\_\_\_\_ Discussed pregnancy implications as appropriate  
 Cholesterol test  Y  N When \_\_\_\_\_ Have you ever had a positive TB test?  Y  N  
 Diabetes test?  Y  N Have you had Pneumovax  Y  N  
 Have you had a flu shot this year?  Y  N