Name:_____ Date:_____
Primary Care Physician:_____ Age:_____

Please fill out this form to your best of your ability by filling in all the areas. Also, if you are a **man greater than 40, please fill out the attached AUA international prostate symptom score.**

Do you have any medical problems (diabetes, high blood pressure, heart disease, etc.)_____
_____
_____

Have you had any surgical procedures?

Procedure	Date	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all illnesses in your immediate family (diabetes, cancer, heart disease)
_____
_____

List all current medications:

Medication name	Dosage	How often do you take it?

Do you have any drug allergies?_____

Social History:
Do you smoke? Circle **Yes** or **No**
When did you **quit**? _____
How many **packs** per day do you or did you smoke? _____
How many **years** have you or did you smoke? _____

Name:_____ Date:_____ Age:_____

Do you drink alcohol? Circle **Yes** or **No**
If yes, how much and how often? _____

Have you ever taken any drugs? (marijuana, cocaine, heroin, etc.)_____
_____

Review of systems:

Do you have or have you ever had any of the following problems?

Overall health			Skin		
Recurrent fevers	Y	N	Rash	Y	N
Recurrent chills	Y	N	Boils	Y	N
Recurrent headaches	Y	N	Persistent itch	Y	N
Eyes			Respiratory		
Blurred vision	Y	N	Productive cough	Y	N
Double vision	Y	N	Short of breath	Y	N
Eye pain	Y	N	Wheezing	Y	N
Ears/Nose			Musculoskeletal		
Ear infections	Y	N	Back problems	Y	N
Sinus pain	Y	N	Muscle pain	Y	N
Post nasal drip	Y	N	Joint problems	Y	N
Gastrointestinal			Mouth		
Abdominal pain	Y	N	Sore throat	Y	N
Nausea/vomiting	Y	N	Bleeding Mass	Y	N
Heartburn/ulcers	Y	N	Ulcer	Y	N
Sexual history (men only)			Urinary System		
Infertility	Y	N	Frequent voiding	Y	N
Premature Ejaculation	Y	N	Night voiding	Y	N
Penile Curvature	Y	N	Painful urination	Y	N
Difficulty with erections	Y	N	Urgency urinating	Y	N
Cardiovascular			Blood		
Chest pain	Y	N	Spontaneous bleeding	Y	N
Leg pain with walking	Y	N	Clotting problems	Y	N
High blood pressure	Y	N	Transfusion reactions	Y	N
Aneurysm	Y	N`	Lymphatic		
Endocrine			Swollen Glands	Y	N
Excessive thirst	Y	N	Recurrent infections	Y	N
Frequently cold	Y	N	Nervous system		
Sluggish/always tired	Y	N	Shaking	Y	N
			Numbness	Y	N
			Previous stroke	Y	N

I certify that the above information is correct to the best of my knowledge.

Signature_____ Date_____

Physician notes: