Date:_____

Name:_____ Date Of Birth: _____/_____/_____

Reason for today's visit:_____

Please Circle All That Apply

Past Medical History: Diabetes, High Blood Pressure, High Cholesterol, Kidney Stones, Blood Clots in Legs or Lungs, Heart Attack, Kidney Failure, Cancer and Type:_____
OTHER Medical Problems:_____

_____

Past Surgical History: Hysterectomy, Gall Bladder Removal, Tonsillectomy, Appendectomy, Heart Bypass, Cardiac Stent, Ureteroscopy for Stones, Shock Wave Lithotripsy (ESWL), Kidney Removal, Prostate Removal, Other Surgeries:_____

_____

Immunizations:

Flu Vaccination **YES/NO** Date_____

Pneumonia Vaccination (Age 65 or older) **YES/NO** Date_____

Medicines/Doses: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies/Reaction: _____ _____ _____

_____ _____ _____ _____

Smoking History:

Packs Per Day:_____ How Many Years:_____ Quit? If so, when?_____

Alcohol Use:_____ **IV Drug Use:**_____

Family Health Problems: Diabetes, High Blood Pressure, High Cholesterol, Kidney Stones, Blood Clots in Legs or Lungs, Heart Attack, Kidney Failure, Cancer and Type:_____
OTHER Family Health Problems:_____

Vitals:

HT _____

WT _____

BP _____

HR _____

Pharmacy / Location:_____

Referring Physician:_____

Primary Care Physician:_____

Date:_____

Name:_____ Date Of Birth:_____/_____/_____

Review of Systems

Do you **currently** have any problems related to the following systems? Circle **Yes** or **No**.

Please explain any YES answers in the space provided.

Genitourinary

Urine Retention	**Y**	**N**
Painful Urination	**Y**	**N**
Urinary Frequency	**Y**	**N**
Other_____		

Eyes

Blurred Vision	**Y**	**N**
Double Vision	**Y**	**N**
Pain	**Y**	**N**
Other_____		

Ear/Nose/Throat/Mouth

Recent Head Injury	**Y**	**N**
Sore Throat	**Y**	**N**
Sinus Pain	**Y**	**N**
Other_____		

Cardiovascular

Chest Pain	**Y**	**N**
Irregular Heartbeat	**Y**	**N**
Other_____		

Respiratory

Shortness of Breath	**Y**	**N**
Wheezing	**Y**	**N**
Frequent Cough	**Y**	**N**
Other_____		

Gastrointestinal

Abdominal Pain	**Y**	**N**
Constipation	**Y**	**N**
Nausea/Vomiting	**Y**	**N**
Indigestion/Heartburn	**Y**	**N**
Other_____		

Musculoskeletal

Joint Pain	**Y**	**N**
Bone Pain	**Y**	**N**
Back Pain	**Y**	**N**
Other_____		

Integumentary

Skin Rash	**Y**	**N**
Boils	**Y**	**N**
Persistent Itch	**Y**	**N**
Other_____		

Neurological

Tremors	**Y**	**N**
Headache	**Y**	**N**
Numbness/Tingling	**Y**	**N**
Seizures	**Y**	**N**
Other_____		

Psychiatric

Depression	**Y**	**N**
Anxiety	**Y**	**N**
Suicidal	**Y**	**N**
Other_____		

Endocrine

Excessive Thirst	**Y**	**N**
Too Hot	**Y**	**N**
Too Cold	**Y**	**N**
Other_____		

Hematologic/Lymphatic

Swollen Glands	**Y**	**N**
Bleeding Disorders	**Y**	**N**
Other_____		

Allergic/Immunologic

Hay Fever	**Y**	**N**
Drug Allergies	**Y**	**N**
Other_____		

Constitutional Symptoms

Fever/Chills	**Y**	**N**
Fatigue	**Y**	**N**
Other_____		