

PAST MEDICAL HISTORY

Name _____

Date _____

Please answer each question by making a check mark (✓) in appropriate boxes, unless otherwise directed.

1. Education:

- Less than High School
- High School completed
- More than High School

2. Occupation (now or last job):

3. Date of last complete medical exam:

- Within last month
- Within last 6 months
- More than 6 months

4. Allergies: Medications, Foods or other.

Substance

Allergic to:

Reaction:

_____	_____
_____	_____
_____	_____

5. Do you drink alcohol?

- Yes No

If yes, indicate number of glasses per week:

- ___ Beer (glasses)
- ___ Wine (glasses)
- ___ Spirits (ounces)

6. Indicate what amount you drink of the following in a typical day:

- ___ Water (8 oz. glasses)
- ___ Juice (8 oz. glasses)
- ___ Coffee (cups)
- ___ Tea (cups)
- ___ Soda (8 oz. glasses)

7. Have you ever been diagnosed or treated for cancer, a tumor, or noticed any lumps or swellings? No Yes Please describe:

8. Have you ever been treated for any of the following:

- | | Yes | No |
|------------------|--------------------------|--------------------------|
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug addiction | <input type="checkbox"/> | <input type="checkbox"/> |

9. Do you have trouble with?

- | | Yes | No |
|---|--------------------------|--------------------------|
| Feeling of tingling or numbness in any parts of your body | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness of arms or legs | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness of one side of your body | <input type="checkbox"/> | <input type="checkbox"/> |

10. Please check the appropriate box(es) if you use any of the following:

- Cane Wheelchair Walker

11. Do you smoke? Yes No

If yes, how many every day?

- ___ Cigarettes
- ___ Cigars
- ___ Pipe
- ___ Chew Tobacco
- ___ Recreational Drugs

Comments: _____

PAST MEDICAL HISTORY

Name _____

Date _____

12. List all medications you are currently taking (prescription & over-the-counter):

Name	Dosage	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

13. Which, if any, of the following have you been treated for.

- | | | |
|---|---|---|
| <input type="checkbox"/> Alzheimer's Disease/Dementia | <input type="checkbox"/> Falls | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fractures/Joint Replacements | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Back Injuries/back compression fractures | <input type="checkbox"/> Heart Disease (CAD, Arrhythmia, Atrial Fibrillation) | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Skin sensitivities or Conditions |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Vascular Disease/PVD |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Other - Specify _____ |
| <input type="checkbox"/> Constipation/Impaction | <input type="checkbox"/> Kidney Stones/Bladder Stones | _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Mitral valve prolapse | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | _____ |

Urological Review - Both Men and Women

Gynecological Review - Women Only

14. Prior Genitourinary history?

- | | |
|---|--|
| <input type="checkbox"/> Hysterectomy _____ Yr. | <input type="checkbox"/> Bladder tumor |
| <input type="checkbox"/> θ Vaginal or Abdominal | <input type="checkbox"/> Bladder suspension |
| <input type="checkbox"/> θ Ovaries Removed | <input type="checkbox"/> Prostatitis/BPH |
| <input type="checkbox"/> Pelvic radiation | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Urethral stricture/Dilatation | |
| <input type="checkbox"/> Discharge - genital area | |
| <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Collagen Injections |
| Date and type _____ | <input type="checkbox"/> Other - Specify _____ |
| <input type="checkbox"/> Itching/odor - genital area/vagina | |

15. Gynecological Review

θ Cystocele θ Uterus Prolapse θ Rectocele

Menstrual Cycle Information

_____ Date of last period

_____ Date of last pap smear

Pregnancy and childbirth information.

Use of: Pessary IUD Diaphragm

Birth Control Specify _____

_____ # of Pregnancies

_____ # of Vaginal deliveries

_____ # of Cesarean sections

_____ # of Episiotomies

Comments: _____

PROVIDER REVIEWED: _____ DATE: _____