



**PAST MEDICAL HISTORY**

**Medical:**

Illness (example: diabetes)

Duration

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**Surgery:**

Operation

Year

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**Medication:** (include vitamins and herbal preparations)

Medicine

Dose

Frequency

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**Allergies to Medication:** \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

List any serious medical conditions and the relationship of that family member to you.

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**SOCIAL HISTORY**

**Tobacco:**     never smoked     former smoker; year that you quit \_\_\_\_\_  
                  current smoker     cigarettes     cigars     pipe    # packs/day \_\_\_\_\_

**Alcohol:**     none     rarely     occasionally     regularly

**Recreational drugs:**     No     Yes (please list): \_\_\_\_\_

## REVIEW OF SYSTEMS:

Please circle any of the following symptoms that are relevant to you and fill in the blanks where indicated. If you do not have any of the symptoms, circle "no problems".

**Constitutional:** no problem    poor appetite    weight loss    weakness    fatigue  
malaise    fever    chills    sweats    pain

**Eyes:** no problem    visual impairment    glaucoma    blurry vision    cataracts

**Ear/Nose/Throat:** no problem    hearing loss    ringing in ear    sinus problems  
loss of smell    swollen glands    hoarseness    sore throat    frequent nosebleeds  
difficulty swallowing

**Heart/Blood Vessels:** no problem    heart failure    palpitations    arrhythmia  
varicose veins    high blood pressure    blocked carotid arteries    angina    heart attack  
buttock pain while walking    leg swelling    heart murmur    blood clot in legs  
blood clot in lungs    elevated cholesterol    aneurysm    valve disease  
mitral valve prolapse

**Respiratory:** no problem    cough    emphysema    coughing blood    asthma  
shortness of breath    tuberculosis

**Intestinal:** no problem    change in bowel habits    constipation    diarrhea    nausea  
vomiting    blood in the stool    ulcers    excessive gas    hepatitis    heartburn  
gallbladder problems    black stools    hiatal hernia    jaundice    hemorrhoids    hernia  
fecal incontinence

**Neurological:** no problems    transient ischemic attacks    stroke    numbness    sciatica  
difficulty walking    excessive headaches    vertigo    tremors    balance problems  
weakness    herniated disk    dizziness    seizures    fainting    forgetfulness    paralysis

**Musculoskeletal:** no problems    muscle weakness    arthritis    backache    gout

**Skin:** no problems    irregular moles    skin cancers    rashes    psoriasis    itching

**Psychiatric:** no problems    anxiety    depression    mania    alcoholism    insomnia  
eating disorder    substance abuse

**Endocrine:** no problems    diabetes    pituitary problems    parathyroid problems  
thyroid problems    adrenal problems    ovarian problems    testes problems  
pancreatic problems    excessive hunger    sluggishness    excessive body hair  
excessive male breast tissue    excessive thirst    hyperactivity    nipple discharge

**Hematological:** no problems    easy bruising    clotting problems    bleeding tendency  
swollen lymph glands    anemia    cancers

**Urinary:** no problems    visible blood in urine    microscopic blood in urine  
difficult urination    painful urination    burning with urination    burning after urination  
urinary infections    cloudy urine    foul smelling urine    air in urine    stool in urine  
hesitant stream    need to strain to pass urine    weak stream    spraying or split stream  
stream that starts and stops    takes a long time to empty    incomplete emptying  
need to urinate twice or more to empty    dribbling after finishing urinating  
frequent urinating    urgent urination    urinary retention    nighttime urinating  
number of nighttime urinations \_\_\_\_\_    difficulty urinating at night but not during day  
leakage on way to toilet    leakage with putting key in door    leakage with cold weather  
leakage with running water    leakage without realizing it    leakage while sleeping  
leakage when getting out of car    leakage with: walking    running    sneezing  
coughing    laughing    shouting    climbing stairs    lifting    bending    standing  
sports    intercourse    orgasm    sitting quietly    continuous leakage  
need to use pads    number of pads/day \_\_\_\_\_    type of pad used \_\_\_\_\_  
kidney infection    kidney mass    kidney obstruction    kidney stones  
flank pain    pubic pain    groin pain    urethral discharge    bladder cancer

**Obstetrical/gynecological (for females only):** age at menstruation \_\_\_\_\_  
age at menopause \_\_\_\_\_    # pregnancies \_\_\_\_\_    # vaginal deliveries \_\_\_\_\_  
#C-sections \_\_\_\_\_    # miscarriages \_\_\_\_\_    # abortions \_\_\_\_\_  
Are you sexually active? yes / no    Are you on hormone replacement? yes / no  
excessive menstrual bleeding    excessive menstrual cramping    ovarian cysts  
uterine fibroids    breast lumps    breast pain    breast discharge    breast cancer  
bulge coming out of vagina    lax vagina    loss of sexual desire    lubrication problems  
painful intercourse    inability to achieve orgasm    infertility  
sexually transmitted diseases

**Males only:** no problems    loss of sexual desire    difficulty achieving an erection  
difficulty maintaining an erection    painful erections    prolonged erections  
angulated erections    blood in semen    premature ejaculation    delayed ejaculation  
inability to ejaculate    painful ejaculation    decreased sensation with orgasm  
infertility    sexually transmitted diseases    penile rash or skin abnormality  
genital warts    foreskin difficulties    prostate enlargement    prostatitis    prostate cancer  
prostate nodule    elevated blood P.S.A.    abnormal urethral opening  
painful testicle    lump on testicle    testes cancer    testes hang too low  
undescended testes    absent testes    shrinking penis

**Any other unlisted problems:**

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**Exercise:** note the type and frequency of your physical activities

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