

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Chart #: \_\_\_\_\_  
 MD: \_\_\_\_\_

**PERSONAL AND MEDICAL HISTORY REVIEW**

Please complete your personal history below.

Please list your **medications**, including **dose** and number of **times per day**: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all **drug allergies** and **reaction** you experienced: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to X/Ray Contrast (Dye)?  Yes  No      Are you allergic to Shellfish?  Yes  No  
 Are you allergic to Latex?  Yes  No

Please list any other known allergies: \_\_\_\_\_  
 \_\_\_\_\_

Please list **Medical Problems** that run in your **Family**:

- Prostate Cancer
- Kidney Stones
- Other - please describe problem(s) below \_\_\_\_\_  
 \_\_\_\_\_

**Habits:**

Tobacco history: packs per day \_\_\_\_\_, years smoked \_\_\_\_\_, when quit \_\_\_\_\_

Alcohol history: \_\_\_\_\_ drinks per week      Caffeinated Beverages: \_\_\_\_\_ per week

**Social history:**

Single or married \_\_\_\_\_ Number of children \_\_\_\_\_ Occupation \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Last menstrual period \_\_\_\_\_

Were you referred by your physician?  Yes  No

If yes, Physician's Name \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please check if you have or have had any of the following (write date next to it).

**Cardiovascular / Peripheral Vascular**

- |   |  |
|---|--|
| <input type="checkbox"/> Abdominal Aortic Aneurysm Repair         | <input type="checkbox"/> Heart Attack                          |
| <input type="checkbox"/> Angina Pectoris (Chest Pain )            | <input type="checkbox"/> Hypercholesterolemia/High Cholesterol |
| <input type="checkbox"/> Aortic Aneurysm                          | <input type="checkbox"/> Hypertension (High Blood Pressure)    |
| <input type="checkbox"/> Aortic Valve Disorder                    | <input type="checkbox"/> Mitral Valve Insufficiency            |
| <input type="checkbox"/> Atrial Fibrillation (Abnormal Heartbeat) | <input type="checkbox"/> Mitral Valve Prolapse                 |
| <input type="checkbox"/> Blood Clot                               | <input type="checkbox"/> Mitral Valve Stenosis                 |
| <input type="checkbox"/> Congestive Heart Disease (Heart Failure) | <input type="checkbox"/> Murmur                                |
| <input type="checkbox"/> Coronary Artery Disease                  | <input type="checkbox"/> Other _____                           |

**Dermatologic**

- Skin Cancer       Psoriasis       Other \_\_\_\_\_

**Endocrine**

- Diabetes Mellitus       Parathyroidectomy (Thyroid removed)  
 Hyperthyroidism       Other \_\_\_\_\_  
 Hypothyroidism

**Gastrointestinal**

- Acid Reflux (GERD)       Liver Failure  
 Appendectomy       Hepatitis  
 Colectomy (Colon Removed)       Hernia  
 Colon Cancer       Jaundice  
 Crohn's Disease       Ulcer  
 Diverticulitis of Colon       Other \_\_\_\_\_

**Genitourinary**

- Acute Prostatitis       Kidney Transplant  
 Adrenal Mass, Not Cancer       Nephrolithiasis (Kidney Stone)  
 Bladder Mass, Not Cancer       Peyronie's Disease  
 Cancer of Adrenal Gland       Prostate Cancer  
 Cancer of Bladder       Sexually Transmitted Disease (VD)  
 Cancer of Kidney, Except Pelvis       Simple Renal Cyst  
 Cancer of Renal Pelvis       Undescended Testicle  
 Cancer of Testis       Urethral Stricture  
 Cancer of Ureter       Urethritis  
 Chronic Prostatitis       Urinary Tract Infection, Cystitis  
 Enlarged Prostate       Vaginal Prolapse (Fallen Bladder)  
 Hypogonadism (Low Testosterone)       Other \_\_\_\_\_  
 Kidney Disease

**GU Surgery**

- Circumcision       Percutaneous Nephrolithotomy (Remove Stone  
Through Back)  
 Cryoablation Kidney (Freeze Tumor)       Prolapse Repair Abdominal  
 Cryoablation Prostate (Freeze Tumor)       Prolapse Repair Vaginal  
 Cystectomy w/Ileal Conduit (Remove Bladder)       Radical Retropubic Prostatectomy  
 Cystectomy w/Neobladder (Remove Bladder)       Robotic Radical Prostatectomy  
 Cystectomy; Partial (Partially Remove Bladder)       Simple Prostatectomy (Open Prostatectomy-Surgery  
Not for Cancer)  
 Cystoscopy (Look in Bladder)       TURBT (Scraping of Bladder Tumor)  
 ESWL (Lithotripsy)       TURP  
 HIFU Prostate       Ureteroscopy \_\_\_\_\_  
 Laser Prostatectomy       Urethral Dilatation  
 Microwave Prostate       Urethral Sling for Incontinence  
 Nephrectomy (Remove Kidney)       Vasectomy  
 Orchiectomy; Bilateral (Remove Testicles)       Vasovasostomy (Vasectomy Reversal)  
 Orchiectomy (Remove Testicle) Left/Right       Other \_\_\_\_\_  
 Penile Prosthesis (Implant)

**Gynecologic**

- |   |  |
|---|--|
| <input type="checkbox"/> Breast Cancer                      | <input type="checkbox"/> Hysterectomy, Abdominal |
| <input type="checkbox"/> Cervical Cancer                    | <input type="checkbox"/> Hysterectomy, Vaginal   |
| <input type="checkbox"/> Cesarean Section                   | <input type="checkbox"/> Menopause               |
| <input type="checkbox"/> Dilation & Curettage of Uterus/D&C | <input type="checkbox"/> Ovarian Cancer          |
| <input type="checkbox"/> Endometriosis                      | <input type="checkbox"/> Uterine Fibroid         |
| <input type="checkbox"/> Fibroid Uterus                     | <input type="checkbox"/> Uterine Lelomyoma       |
| <input type="checkbox"/> Hysterectomy, Total                | <input type="checkbox"/> Other _____             |

**Musculoskeletal**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Discectomy  |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Other _____ |

**Neurologic**

- |  |  |
|--|--|
| <input type="checkbox"/> CVA (Stroke)            | <input type="checkbox"/> Spina Bifida    |
| <input type="checkbox"/> Multiple Sclerosis (MS) | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Paraplegia (Paralysis)  | <input type="checkbox"/> Other _____     |

**Pulmonary**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Allergic Rhinitis (Seasonal Allergies) | <input type="checkbox"/> Lung Cancer  |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Sleep Apnea  |
| <input type="checkbox"/> COPD (Chronic Bronchitis/Emphysema)    | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Exposure to Asbestos                   | <input type="checkbox"/> Other _____  |

**Surgical**

- |  |  |
|--|--|
| <input type="checkbox"/> Abdominal Aortic Aneurysm Repair                | <input type="checkbox"/> Hysterectomy, Total       |
| <input type="checkbox"/> Appendectomy                                    | <input type="checkbox"/> Hysterectomy, Abdominal   |
| <input type="checkbox"/> Arthroscopy of Knee                             | <input type="checkbox"/> Hysterectomy; Vaginal     |
| <input type="checkbox"/> Arthroscopy of Shoulder                         | <input type="checkbox"/> Lobectomy, Partial (Lung) |
| <input type="checkbox"/> Cesarean Section                                | <input type="checkbox"/> Lobectomy, Total (Lung)   |
| <input type="checkbox"/> Colon Removal                                   | <input type="checkbox"/> Pneumonectomy             |
| <input type="checkbox"/> Colostomy                                       | <input type="checkbox"/> Tonsillectomy             |
| <input type="checkbox"/> Coronary Angioplasty(Balloon w/ or w/out Stent) | <input type="checkbox"/> Transplantation, Liver    |
| <input type="checkbox"/> Gall Bladder Removal                            | <input type="checkbox"/> Transplantation, Lung     |
| <input type="checkbox"/> Gastrectomy (Remove Stomach)                    | <input type="checkbox"/> Transplantation, Kidney   |
| <input type="checkbox"/> Heart Bypass (CABG)                             | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Herniorrhaphy (Hernia Repair)                   | <input type="checkbox"/> Other _____               |

**Review Of Symptoms  
Current Symptoms and Medical Conditions**

**General**

- Chills
- Fever
- Weight Gain
- Weight Loss

**Skin**

- Genital Lesion
- Hair Growth

**HEENT**

- Double Vision
- Headache
- Head Injury
- Hearing Loss
- Seasonal Allergies
- Visual Loss

**Neck**

- Neck Mass

**Respiratory**

- Chronic Cough
- Decreased Exercise Tolerance
- Difficulty Breathing
- Snoring

**Breast**

- Breast Mass
- Breast Pain
- Breast Swelling

**Cardiovascular**

- Chest Pain
- Difficulty Breathing Lying Down
- Difficulty Breathing on Exertion
- Elevated Blood Pressure
- Irregular Heart Beat
- Shortness of Breath

**Gastrointestinal**

- Abdominal Mass
- Abdominal Pain
- Constipation
- Diarrhea
- Nausea
- Vomiting

**Female Genitourinary**

- Discharge
- Dysmenorrhea - painful periods
- Dyspareunia - pain with intercourse
- Menstrual Irregularities
- Vaginal Bleeding
- Vaginal Discharge
- Vaginal dryness
- Vaginal itching/burning

**Musculoskeletal**

- Backache
- Swelling of Extremities

**Neurological**

- Focal Neurological Symptoms
- Headaches
- Incontinence - Stool
- Incontinence - Urine

**Psychiatric**

- Anxiety
- Depression
- Panic Attacks

**Endocrine**

- Diabetes
- Thyroid Problem

**Hematology**

- Abnormal Bleeding
- Anemia
- Blood Clots
- Easy Bruising
- Enlarged Lymph Nodes

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**PHARMACY INFORMATION**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone Number: \_\_\_\_\_