Name: _____
Date of Birth: _____
Primary Doctor: _____

Surgery/Urology at Memorial Hospital

WHY ARE YOU HERE TODAY?
(Reason for Today's Visit)

REFERRING DOCTOR: (or Primary Care Doctor)

PATIENT MEDICAL HISTORY
(Please Circle)

Arthritis/Gout	Yes	No
Bleeding	Yes	No
Cancer	Yes	No
Convulsions	Yes	No
Diabetes	Yes	No
Heart Trouble	Yes	No
Hypertension	Yes	No
Kidney Disease	Yes	No
Stones	Yes	No
Stroke	Yes	No

FAMILY MEDICAL HISTORY
(Please Circle)

Arthritis/Gout	Yes	No
Bleeding	Yes	No
Cancer	Yes	No
Convulsions	Yes	No
Diabetes	Yes	No
Heart Trouble	Yes	No
Hypertension	Yes	No
Kidney Disease	Yes	No
Stone	Yes	No
Stroke	Yes	No

LIST ALL OPERATIONS/SURGERIES & DATES
HOSPITALIZATIONS

LIST ALL OTHER

_____
_____
_____
_____
_____

List all ALLERGIES to:

Medications	❑ No	❑ Yes(Please List)	_____
Seasonal Allergies	❑ No	❑ Yes	
Food Allergies	❑ No	❑ Yes	
Iodine / Seafood	❑ No	❑ Yes	
Latex	❑ No	❑ Yes	

Patient Social History:

Alcohol:	❑ Never	❑ Rarely	❑ Weekly	❑ Daily			
Caffeine:	❑ Never	❑ Cup/day ____					
Children:	❑ Sons	❑ Daughters	❑ None				
Street Drugs:	❑ Never	❑ Type/ Frequency					
Tobacco:	❑ Never	❑ Quit _____year	❑ Yes (packs/ day)	_____			

REVIEW OF SYSTEMS Please Answer YES or NO to all Questions Below:

CONSTITUTIONAL

Good Health Lately	❑ No	❑ Yes
Recent Weight Change	❑ No	❑ Yes
Fever	❑ No	❑ Yes
Fatigue	❑ No	❑ Yes
Headaches	❑ No	❑ Yes

EYES

Eye Disease or Injury	❑ No	❑ Yes
Glasses / Contacts	❑ No	❑ Yes
Blurred Vision	❑ No	❑ Yes
Glaucoma	❑ No	❑ Yes

ENT

Hearing Loss/ Ringing	❑ No	❑ Yes
Earache / Drainage	❑ No	❑ Yes
Chronic Sinus	❑ No	❑ Yes
Nose Bleeds	❑ No	❑ Yes
Mouth Sores	❑ No	❑ Yes
Bleeding gums	❑ No	❑ Yes
Bad Breath/ Taste	❑ No	❑ Yes
Voice Change	❑ No	❑ Yes
Sore Throat	❑ No	❑ Yes
Swollen Glands	❑ No	❑ Yes

CARDIOVASCULAR

Heart Trouble	❑ No	❑ Yes
Chest Pain	❑ No	❑ Yes
Palpitation	❑ No	❑ Yes
Swelling of Feet	❑ No	❑ Yes

RESPIRATORY

Chronic Cough	❑ No	❑ Yes
Spitting up Blood	❑ No	❑ Yes
Shortness of Breath	❑ No	❑ Yes
Asthma/Wheezing	❑ No	❑ Yes

GASTROINTESTINAL

Loss of Appetite	❑ No	❑ Yes
Change in Bowel Habits	❑ No	❑ Yes
Nausea / Vomiting	❑ No	❑ Yes
Frequent Diarrhea	❑ No	❑ Yes
Constipation	❑ No	❑ Yes
Rectal Bleeding	❑ No	❑ Yes
Black/ Light Stools	❑ No	❑ Yes
Heartburn/ Stomach Pain	❑ No	❑ Yes
Gastritis or Ulcer	❑ No	❑ Yes

MUSCULOSKELETAL

Joint Pain	❑ No	❑ Yes
Joint Stiffness	❑ No	❑ Yes
Weakness of Muscle	❑ No	❑ Yes
Muscle Pain or Cramp	❑ No	❑ Yes
Cold Extremities	❑ No	❑ Yes
Difficulty Walking	❑ No	❑ Yes

INTEGUMENTARY

Rash or Itching	❑ No	❑ Yes
Change in Skin Color	❑ No	❑ Yes
Change in Hair or Nails	❑ No	❑ Yes
Varicose Veins	❑ No	❑ Yes
Breast Pain/ Discharge	❑ No	❑ Yes
Breast Lump	❑ No	❑ Yes

NEUROLOGICAL

Frequent Headaches	❑ No	❑ Yes
Light-Headed/ Dizzy	❑ No	❑ Yes
Seizures	❑ No	❑ Yes
Numbness- Tingling	❑ No	❑ Yes
Tremors	❑ No	❑ Yes
Paralysis	❑ No	❑ Yes
Stroke	❑ No	❑ Yes
Head Injury	❑ No	❑ Yes

PSYCHIATRIC

Memory Loss/Confusion	❑ No	❑ Yes
Nervousness	❑ No	❑ Yes
Depression	❑ No	❑ Yes
Insomnia	❑ No	❑ Yes

ENDOCRINE

Gland/Hormone Problems	❑ No	❑ Yes
Thyroid Disease	❑ No	❑ Yes
Excessive Thirst/Urination	❑ No	❑ Yes
Heat/ Cold Intolerance	❑ No	❑ Yes
Skin becoming drier	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes

HEMATOLOGICAL/ LYMPHATIC

Slow to Heal	❑ No	❑ Yes
Bleeding/Bruising Easily	❑ No	❑ Yes
Anemia	❑ No	❑ Yes
History Transfusions	❑ No	❑ Yes
Enlarged Glands	❑ No	❑ Yes

Please Answer YES or NO to all Questions Below:

GENITOURINARY

Frequent Urination	❑ No	❑ Yes
Burning/Painful Urination	❑ No	❑ Yes
Blood in Urine	❑ No	❑ Yes
Straining to Urinate	❑ No	❑ Yes
Incontinence	❑ No	❑ Yes
Kidney Stones	❑ No	❑ Yes
Sexual Difficulty	❑ No	❑ Yes
Voiding Difficulties	❑ No	❑ Yes

ADDITIONAL COMMENTS:

WOMEN ONLY

Painful Periods	❑ No	❑ Yes
Irregular Periods	❑ No	❑ Yes
Vaginal Discharge	❑ No	❑ Yes

Number of Pregnancies _____

Date of last PAP smear _____

Date of last Mammogram _____

Date of first Period _____

Date of last Period _____

Date you stared Menopause _____

List ALL medications that you are currently taking INCLUDING ALL OVER THE COUNTER MEDICATIONS AND VITAMINS/MINERALS & HERBAL SUPPLEMENTS.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

DO YOU TAKE ASPIRIN ON A REGULAR BASIS?	❑ No	❑ Yes
DO YOU HAVE CARDIAC STENTS?	❑ No	❑ Yes
DO YOU HAVE SLEEP APNEA?	❑ No	❑ Yes
DO YOU HAVE AN ADVANCE DIRECTIVE? (Living will)	❑ No	❑ Yes