Previous Medical History: Have you ever had any of the following conditions?

	Yes	No	Date	Description
Heart Attack	☐	☐		
High Blood Pressure	☐	☐		
High Cholesterol	☐	☐		
Diabetes	☐	☐		
Thyroid Disorder	☐	☐		
Hormone Imbalance	☐	☐		
Multiple Sclerosis	☐	☐		
Prostate Problems	☐	☐		
Head Injury	☐	☐		
Spinal Cord Injury	☐	☐		
Back Injury	☐	☐		
Sickle Cell or Trait	☐	☐		
Cancer	☐	☐		
Psychological Problems	☐	☐		
Broken Bones	☐	☐		
HIV or AIDS	☐	☐		
Urinary infection	☐	☐		
Venereal disease	☐	☐		
Penile injury	☐	☐		
Heart murmur	☐	☐		
Hepatitis	☐	☐		

List all operations, hospitalizations, and other medical conditions:

Date	

For women only:

How many times have you been pregnant?__________

How many vaginal deliveries:__________

How many Cesarean deliveries?__________

Have you gone through menopause? Yes No If yes, when?__________

Please **list <u>all medications</u>** you are currently taking:

Medication Name	Dose	Frequency	When Began
______________	_______	__________	_______________
______________	_______	__________	_______________
______________	_______	__________	_______________
______________	_______	__________	_______________
______________	_______	__________	_______________
______________	_______	__________	_______________
______________	_______	__________	_______________
______________	_______	__________	_______________
______________	_______	__________	_______________
______________	_______	__________	_______________

Allergies:

Are you allergic to **penicillin**? Yes No

Are you allergic to **Iodine** given for X-rays? Yes No

Are you allergic to any other medications or things? Yes No If Yes, explain:

____

____

Family History: Has anyone in your family been treated for any of the following conditions:

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Stroke	☐	☐
Heart Disease	☐	☐	Cancer	☐	☐
Prostate cancer	☐	☐	Diabetes	☐	☐

(If your brother or father had prostate cancer, you are at increased risk and should be checked at least once yearly.)

Is your mother alive_____ deceased_____; if deceased, cause of death:____________

Is your father alive_____ deceased_____; if deceased, cause of death:____________

Social History:

Marital Status: (circle) Single Married Divorced Widowed

Number of Marriages: _____ Number of children:__________

Have you ever smoked cigarettes? Yes No Cigars? Yes No

How many total years have you smoked? _______

On average, how many packs per day have you smoked? _____

If you have quit smoking, when did you quit? __________

Packs-years:_________

Do you use ever alcohol? Yes No

What do you drink?____

How many days per week do you drink any alcohol?_____________________________

What is the average amount of alcohol you drink on those days?______________________

What is the most you would drink in any one day?_______________

Have you ever been treated for alcoholism? Yes No

Have you ever used any street drugs? Yes No

Type:___________________________ Frequency:___________ For how long?__________

Do you ride a bike frequently? Yes No

Review of Systems

Have you noticed any of the following symptoms over the last month?
Circle all that apply:

- Fever
- Chills
- Weight loss
- Night sweats
- Hearing loss
- Loss of smell
- Nosebleeds
- Sinus trouble
- Dental problems
- Swollen ankles
- Headaches
- Vision changes
- Thirsty all the time
- Cold most of the time
- Difficulty swallowing
- Nausea or vomiting
- Diarrhea
- Constipation
- Bloody bowel movements
- Unusually tired
- Hemorrhoids
- Skin rash
- Itchy skin
- Psoriasis
- Skin Ulcers
- Tingling
- Swollen ankles
- Hives
- Pain radiating down legs
- Dizziness
- Sciatica
- Arthritis
- Back pain
- Swollen joints
- Unusually nervous
- Shortness of breath
- Back pain
- Chest pain
- Frequent cough
- Wheezing
- Discharge from penis
- Leg cramps
- Wake up short of breath
- Heart murmur
- Lump on testicle
- Lump on penis
- Blood in urine
- Painful urination
- Difficulty passing urine
- Difficulty controlling urination
- Getting up at night to urinate
- Excessive sweating
- Anxiety
- Depression
- Mood swings
- Numbness
- Phobias
- Easy bruising
- Weakness
- Loss of balance
- Fainting
- Pinched nerve

What is your:

Height: **Weight:**