PATIENT HISTORY

Today's Date _____

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR HEALTH. PLEASE TAKE TIME TO FULLY AND COMPLETELY FILL OUT THIS IMPORTANT INFORMATION. WE ARE COUNTING ON YOU.

Last Name_____ First Name_____ MI _____ DOB____/____/____

List All Allergies to Medications (including iodine and shellfish allergies)_____

Have you ever had any problems with Anesthesia? Yes No

If yes, please explain_____

Past Medical History (Circle those that apply to you and list all other health problems)

Asthma	Heart Disease	Implanted Pacemaker	Previous Transfusions
Cancer (_____)	Hepatitis (Type____)	Kidney Failure	Thyroid Problems
Diabetes	High Blood Pressure	Kidney Stones	Tuberculosis
Depression	High Cholesterol	Mitral Valve Prolapse	
Emphysema	H.I.V. / A.I.D.S.	Multiple Sclerosis	
Glaucoma	Implanted Defibrillator	Parkinson's Disease	

Other Illnesses:

_____ _____ _____

_____ _____ _____

Do you use a ventilation device such as CPAP or BiPAP? (Please circle) Yes No

Do you require Antibiotics to be given routinely before procedures? (please circle) Yes No

If yes, reason why?_____

Antibiotics and Doses taken_____

Past Surgical History (List all of your prior operations, dates performed and reason for them)

_____ Date	_____ Date	_____ Date
_____ Date	_____ Date	_____ Date
_____ Date	_____ Date	_____ Date

Social History

Occupation_____ Marital Status_____ # of Children_____

Do you currently use tobacco, cigarettes or pipes? Yes No If yes, how much per day? _____

Have you used tobacco products in the past? Yes No If yes, how many years? _____

Do you use alcohol? Yes No If yes, how often and how much_____

Reviewing Physician's Signature

_____ Date	_____ Date	_____ Date
_____ Date	_____ Date	_____ Date

Family History (circle answer and list the family member's relationship to you)

Has anyone had prostate cancer?	Yes	No	Who?_____
Has anyone had bladder cancer?	Yes	No	Who?_____
Has anyone had kidney cancer?	Yes	No	Who?_____
Has anyone had kidney stones?	Yes	No	Who?_____

List any other immediate family member's serious illnesses_____

_____

_____

Review of Systems (Do you have any recent problems with the following systems? Circle answer)

Constitutional:	Fever	Yes	No	Weight Loss	Yes	No
Integumentary:	Skin Rash	Yes	No	Persistent Skin Itch	Yes	No
Eyes:	Blurred Vision	Yes	No	Eye Pain	Yes	No
Ear/Nose/Throat:	Sinus Problems	Yes	No	Ear Infections	Yes	No
Respiratory:	Short of Breath	Yes	No	Wheezing	Yes	No
Cardiovascular:	Chest Pain	Yes	No	Varicose Veins	Yes	No
Gastrointestinal:	Vomiting	Yes	No	Diarrhea	Yes	No
Musculoskeletal:	Back Pain	Yes	No	Joint Pain	Yes	No
Genitourinary:	Urine Retention	Yes	No	Painful Urination	Yes	No
Neurological:	Dizzy Spells	Yes	No	Numbness/Tingling	Yes	No
Hematologic/Lymphatic:	Swollen Glands	Yes	No	Anemia	Yes	No
Endocrine:	Excessive Thirst	Yes	No	Excessive Fatigue	Yes	No
Allergy/Immunologic:	Hay Fever	Yes	No	Trouble Clearing Infection	Yes	No
Gynecological:	Uterine Fibroids	Yes	No	Pelvic Pain	Yes	No

Date of Last Menstrual Period____/____/____

Psychiatric:	Are you satisfied with your life?	Yes	No
	Do you feel severely depressed?	Yes	No

List any other problems and explain any yes answers_____

_____

_____

Patient or POA/Guardian Statement:

I certify that the information provided on the Patient History Form is accurate and complete.
I attest that the patient's entire medical and surgical history has been listed.

Patient/POA Signature_____Today's Date _____