Name: _____ Today's Date _____

DOB _____ Who Referred you to our office? _____

Please list why are you being seen by a surgeon today: (Please included how long you have had this problem and what makes it worse)

_____

_____

Please list your current medication: ☐ I have provided a written list of my medication.

Medication	Strength	How Often

Please list all major medical conditions you have or have experienced in the past.

Condition	Date (Month / Year)

Please list any know Allergies ☐ I have no known allergies

Allergy	Type of Reaction

Please list all previous surgeries with approximate dates

Surgery	Date (Month / Year)

Please list any hospitalizations (other than surgeries) with approximate dates

Hospitalization	Date (Month / Year)

Family History: Are you adopted? ☐ Yes ☐ No

Family Member	Status A - Alive D - Deceased U - Unknown	Year of Birth	Age (Years)	Known Medical Condition or cause of death
MOTHER	☐A ☐D ☐U			
FATHER	☐A ☐D ☐U			
BROTHER	☐A ☐D ☐U			
BROTHER 2	☐A ☐D ☐U			
BROTHER 3	☐A ☐D ☐U			
SISTER	☐A ☐D ☐U			
SISTER 2	☐A ☐D ☐U			
SISTER 3	☐A ☐D ☐U			
DAUGHTER	☐A ☐D ☐U			
DAUGHTER 2	☐A ☐D ☐U			
DAUGHTER 3	☐A ☐D ☐U			
SON	☐A ☐D ☐U			
SON 2	☐A ☐D ☐U			
SON 3	☐A ☐D ☐U			
MATERNAL GRANDMOTHER	☐A ☐D ☐U			
MATERNAL GRANDFATHER	☐A ☐D ☐U			
PATERNAL GRANDMOTHER	☐A ☐D ☐U			
PATERNAL GRANDFATHER	☐A ☐D ☐U			

Social History: Do you use tobacco products? ☐Y / N☐ ☐Former If Yes, what type, how often? _____

Alcohol Use: _____ Heavily _____ Moderately _____ Socially

_____ Occasionally _____ Rarely _____ Never

Review of Systems					
Fever	Y☐ /☐N	Shortness of Breath	Y☐ /☐N	Scrotal Mass	Y☐ /☐N
Chills	Y☐ /☐N	Asthma	Y☐ /☐N	Prostate Problems	Y☐ /☐N
Weight Loss	Y☐ /☐N	Nausea	Y☐ /☐N	Blood in Urine	Y☐ /☐N
Tiredness	Y☐ /☐N	Belly Pain	Y☐ /☐N	Frequent Urination	Y☐ /☐N
Hard of Hearing	Y☐ /☐N	Hernias	Y☐ /☐N	Difficulty Urinating	Y☐ /☐N
Poor Eyesight	Y☐ /☐N	Change in bowel habits	Y☐ /☐N	Urine leakage	Y☐ /☐N
Blurry Vision	Y☐ /☐N	Constipation	Y☐ /☐N	Irregular Periods	Y☐ /☐N
Chest Pain	Y☐ /☐N	Hemorrhoids	Y☐ /☐N	Vaginal Discharge	Y☐ /☐N
Cough	Y☐ /☐N	Diarrhea / Irritable Bowel	Y☐ /☐N	Dizziness	Y☐ /☐N
Poor Circulation	Y☐ /☐N	Rectal Pain	Y☐ /☐N	Fainting	Y☐ /☐N
Unable to Lie Flat	Y☐ /☐N	Bleeding Problems	Y☐ /☐N	Breast Pain	Y☐ /☐N
Ankle swelling	Y☐ /☐N	Pain with Eating	Y☐ /☐N	Breast Lumps	Y☐ /☐N
Irregular Heartbeat	Y☐ /☐N	Trouble Swallowing	Y☐ /☐N	Nipple Discharge	Y☐ /☐N
Leg Pain when Walking	Y☐ /☐N	Vomiting	Y☐ /☐N	Are you Pregnant	Y☐ /☐N
Are you Breast Feeding	Y☐ /☐N				