

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	Year of Birth	Age (Years)	Known Medical Condition or cause of death
	A - Alive D - Deceased U - Unknown			
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				