

PATIENT'S NAME: _____

DOCTOR'S NAME: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GU (GENITALURINARY):

FEMALES:

HISTORY OF PELVIC INFLAMMATORY DISEASE _____

URINARY TRACT INFECTIONS _____

BREAST CANCER &/OR BENIGN TUMORS _____

BLOOD IN URINE _____

VAGINAL DISCHARGE _____

PMS _____

LOSS OF BLADDER CONTROL _____

CURRENTLY PREGNANT _____

USE BIRTH CONTROL _____

DATE OF LAST MENSTRUAL PERIOD (DLMP) _____

IF INDICATED AGE OF MENOPAUSE _____

LAST PELVIC EXAM (DATE & RESULTS) _____

LAST PAP SMEAR (DATE & RESULTS) _____

LAST BREAST EXAM (DATE & RESULTS) _____

ANY SEXUALLY TRANSMITTED DISEASE (STD) _____

MALES

PROSTATE PROBLEMS _____

HERNIA _____

PENILE DISCHARGE _____

BLOOD IN URINE _____

PAINFUL URINATION _____

FREQUENT URINATION _____

TESTICULAR PAIN _____

LOSS OF BLADDER CONTROL _____

LAST PROSTATE EXAM (DATE & RESULTS) _____

LAST PSA (DATE & RESULTS) _____

ANY SEXUALLY TRANSMITTED DISEASE (STD) _____

ENDOCRINE:

COLD OR HEAT INTOLERANCE _____

EXCESSIVE SWEATING _____

EXCESSIVE THIRST OR HUNGER _____

DIABETES (IF YES INDICATE IF INSULIN DEPENDENT)

THYROID PROBLEMS _____

KIDNEY PROBLEMS _____

SOCIAL HISTORY:

USE TOBACCO (SMOKE) IF YES INDICATE HOW MUCH AND HOW LONG BEEN SMOKING

USE ALCOHOL (DRINK) IF YES INDICATE HOW MUCH AND HOW OFTEN:

Daily
Weekly
Monthly

PARENT / GUARDIAN SIGNATURE: (if patient under 18)

X _____

DATE:

X _____

PATIENT SIGNATURE:

X _____

DATE:

X _____