HEALTH HISTORY/INFORMATION 4/3/14

Name_____ Date of Birth_____
Primary Care Physician_____ Weight_____
Phone Number (PCP)_____ Height_____
Local Pharmacy_____ Referred BY:
Pharmacy Phone Number_____ _____

CHIEF COMPLAINT (Why you are here to see our physician) Female ☐ Male ☐

MEDICAL HISTORY

	Yes	No
Diabetes……..	☐	☐
High Blood Pressure…..	☐	☐
Cancer……..	☐	☐
Stroke……..	☐	☐
Heart Attack……..	☐	☐
Bleeding Tendency….....	☐	☐
Venereal Disease…….	☐	☐
Hereditary Defects…….	☐	☐
Thyroid Disease……	☐	☐
Vasectomy……..	☐	☐
Tubal Ligation……..	☐	☐

Other_____

PREVIOUS SURGERIES/HOSPITALIZATIONS/INJURIES

_____Date_____
_____Date_____
_____Date_____
_____Date_____

ALLERGIES	YES	NO	TYPE OF REACTION
Shellfish……..	☐	☐	_____
Iodine…….	☐	☐	_____
Latex……..	☐	☐	_____

Other…….._____
Medication Allergies_____
_____
_____

SOCIAL HISTORY

Marital Status:
Single ☐
Married ☐
Divorced ☐
Widowed ☐

Use of Alcohol:
Never ☐
Rarely ☐
Moderate ☐
Daily ☐

Use of Tobacco:
Never ☐
Previously, but quit ☐
Currently ☐
Packs per day_____

Use of Drugs:
Never ☐
Currently ☐
Type_____
Frequency_____

Excessive exposure at home or work to Fumes?
Yes ☐ No ☐

FAMILY MEDICAL HISTORY

	Age	Deceased	Diseases	If Deceased, Cause of Death
Father	_____	☐	_____	_____
Mother	_____	☐	_____	_____
Siblings	_____	☐	_____	_____
	_____	☐	_____	_____
	_____	☐	_____	_____
Spouse	_____	☐	_____	_____
Children	_____	☐	_____	_____
	_____	☐	_____	_____
	_____	☐	_____	_____

REVIEW OF SYSTEMS

CONSTITUTION SYMPTOM	Yes	No
You've had good general health lately…..	☐	☐
Recent weight change……	☐	☐
Fever……..	☐	☐
Fatigue……..	☐	☐
Headaches……..	☐	☐

EYES	Yes	No
Wear glasses……	☐	☐
Blurred or double vision……..	☐	☐
Glaucoma……	☐	☐

CARDIOVASCULAR	Yes	No
Chest pain or angina pectoris…….	☐	☐
Palpitation……	☐	☐
Swelling of feet ……..	☐	☐
Swelling of ankle…….	☐	☐
Swelling of hand…….	☐	☐

RESPIRATORY	Yes	No
Chronic frequent coughs……	☐	☐
Shortness of breath……	☐	☐
Asthma or wheezing…….	☐	☐

GASTROINTESTINAL	Yes	No
Loss of appetite……..	☐	☐
Change in bowel movements……..	☐	☐
Nausea or vomiting…….	☐	☐
Frequent diarrhea……..	☐	☐
Painful bowel movements or Constipation……	☐	☐
Rectal bleeding or blood in stool……..	☐	☐
Abdominal pain or Heartburn…….	☐	☐
Peptic ulcer (stomach or duodenal)…….	☐	☐

Female:	Yes	No
Pain with periods…….	☐	☐
Irregular periods……..	☐	☐
Vaginal discharge……	☐	☐

Date of Last menstrual cycle_____

Date of Last pap smear_____

# of Pregnancies # of Vaginal deliveries # of C-sections # of Miscarriages

MUSCULOSKELETAL	Yes	No
Joint Pain……	☐	☐
Back Pain……	☐	☐
Difficulty walking…….	☐	☐

NEUROLOGICAL	Yes	No
Frequent recurring headaches…	☐	☐
Convulsions or Seizures…….	☐	☐
Head Injury……	☐	☐

PSYCHIATRIC	Yes	No
Memory loss or confusion……..	☐	☐
Nervousness……..	☐	☐
Depression…….	☐	☐

ENDOCRINE	Yes	No
Thyroid disease……..	☐	☐
Excessive thirst or urination……..	☐	☐

HEMATOLOGIC/LYMPHATIC	Yes	No
Slow to heal after cuts……..	☐	☐
Anemia……	☐	☐
Past transfusion……	☐	☐

GENITOURINARY	Yes	No
Frequent urination……	☐	☐
Burning or painful urination……..	☐	☐
Blood in urine……	☐	☐
Change in force or strain when urinating……..	☐	☐
Incontinence or dribbling……..	☐	☐
Kidney Stones……	☐	☐
Sexual difficulty……..	☐	☐

CURRENT MEDICATIONS AND MILLIGRAMS

_____

_____

_____

_____

_____

**LIST ADDITIONAL MEDS ON BACK OF SHEET

Male:	Yes	No
Testicle pain……	☐	☐

Overactive Bladder (OAB) Symptom Quiz

The questions below ask about how bothered you may be by some bladder symptoms. Some people are bothered by bladder symptoms and may not realize that there are treatments available for their symptoms. This quiz is an awareness tool that can help you talk to your doctor about your symptoms. It cannot give you a diagnosis.

Please circle the number that best describes how much you have been bothered by each symptom. Add the numbers together for a total score and record the score in the box provided at the bottom.

How bothered have you been by….	**Not At all**	**A little bit**	**Some-what**	**Quite a bit**	**A great deal**	**A very great deal**
1. Frequent urination during the daytime hours?	0	1	2	3	4	5
2. An uncomfortable urge to urinate?	0	1	2	3	4	5
3. A sudden urge to urinate with little or no warning?	0	1	2	3	4	5
4. Accidental loss of small amounts of urine?	0	1	2	3	4	5
5. Nighttime urination?	0	1	2	3	4	5
6. Waking up at night because you had to urinate?	0	1	2	3	4	5
7. An uncontrollable urge To urinate?	0	1	2	3	4	5
8. Urine loss associated with a Strong desire to urinate?	0	1	2	3	4	5
Are you male?	If male, add 2 points to your score					

Adapted from Coyned, KS, Zyczynski T, Margolis MK, Elinoff V, Roberts RG. Validation of an overactive bladder awareness toll for use in primary care settings. Adv Ther. 2005;22:381-394.

Please add up your responses to the questions above ☐

Please hand this page to your physician or healthcare professional when you see him/her for your visit.

Note: You may be asked to give a urine sample. Please ask before going to the bathroom.