AGE:_____

MEDICAL INFORMATION FORM

NAME:_____ **Date of Birth:**_____ **Medical Dr.** _____

Main reason for office visit today:_____

Y / N Slow stream
Y / N Frequent urination
Y / N Trouble starting urine
Y / N Not emptying bladder
Y / N Burning with urination
Y / N Blood in the urine
Y / N Back pain
Y / N Fever chills

YEAR	**ALL SURGERIES**
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL ILLNESSES (Record Year Diagnosed)

_____Diabetes
_____High Blood Pressure
_____Heart Attack
_____Heart Surgery
_____Angioplasty
_____Heart Stent
_____Lung disease
_____Diverticulosis
_____Seizures
_____Stroke
_____Kidney Stones
_____Kidney Infections
_____Bladder Infections
_____Incontinence
_____Impotence
_____Other_____

Do you smoke? Y / N Ever Smoked? Y / N Quit When? _____

Alcohol? Y / N If yes, do you drink more than 3 beers, drinks, or glasses of wine /day Y / N

Marital Status: __Single __Married __Divorced ____ # of Children

Employer/Job: _____ Retired from _____

DISEASES THAT RUN IN YOUR FAMILY: Y / N Heart disease Y / N Diabetes
Y / N Stroke Y / N Prostate Cancer Y / N Kidney Stones Other: _____

PHYSICAL EXAM: __Healthy __Chronically ill __Pale __Elderly __ Obese male in NAD.
__writhing in pain __uncomfortable VSS recorded in the chart are reviewed.

LUNGS: __non labored breathing

ABD: __soft
__nontender
__no masses
__L/S normal
__scafoid
__protuberant
__obese
__bladder palp
__CVAT

CNS: __ alert and oriented X 3

GU Exam : __Nl circ __Nl uncirc penis
__no masses,induration, placques
__testicles w/o masses nor indur.
__epididymis nl __tender on __side(s)
__enlarged on __side(s)

INGUINAL NODES: __nonpalpable __shotty,nonpathologic __enlarged __tender __pathologic

Rectal Exam: __Normal Sphincter tone
__Lax Sphincter tone
____FR foley draining clear urine

Prostate: __smooth, non-nodular w/o induration.
__+ enlarged
__nodule in Zone _____
__asymmetric w/ the ___side larger

PATIENT NAME: _____

BIRTHDATE: _____ PHARMACY # _____

MEDICATION INFO	DATE	DATE	DATE	DATE	DATE

REVIEW OF SYSTEMS:

Do you now or have you recently had any problems related to the following? CIRCLE Yes (Y) or No (N)

Constitutional Symptoms
Fever Y N
Chills Y N
Wt. Loss Y N

Endocrine
Excessive Thirst Y N
Too hot/cold Y N
Sluggish/Tired Y N

Immunological
HIV Positive Y N
AIDS Y N

Respiratory
Wheezing Y N
Short of Breath Y N
Productive Cough Y N

Gastrointestinal
Abdominal Pain Y N
Nausea/Vomiting Y N
Constipation Y N
Diarrhea Y N

Cardiovascular
Chest Pain Y N
Leg Pain Y N
(walking) Y N

Musculoskeletal
Joint Pain Y N
Back Pain Y N

Skin
Rash/Itch Y N

Psychological
Depression Y N
Suicidal Thoughts Y N
Meds for Above Y N

Genitourinary
Pain urinating Y N
Blood in Urine Y N
Foley Catheter Y N

DATE REVIEWED AND/OR AMENDED BY PHYSICIAN:
1.) _____ 2.) _____
3.) _____ 4.) _____
5.) _____

ALLERGIES: _____
_____