PATIENT HISTORY FORM

Last Name: ______________________ First: ______________________ Middle: ______________

Today's Date: ____/____/____ Date of Birth: ____/____/____

You live with (circle) spouse family self at a nursing home

MEDICATIONS

Name	Milligrams (amount)	Times a Day

MD USE ONLY

List any Medication Allergies:

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Dye Y N Iodine Y N

Seafood Y N Latex Y N

Other: ______________________

List Any Past Surgeries:

Type	Date (Year only)

Family History Of:

Prostate Cancer Y N

Heart Disease Y N

Diabetes Y N

Cancer Y N

Other: ______________________

Your Other Medical Illnesses:

			WHEN
Lung Disease	Y	N	
Diabetes	Y	N	
Heart Attack	Y	N	
Stroke	Y	N	
Tuberculosis	Y	N	
High Blood Pressure	Y	N	
Heart Murmur	Y	N	
Arthritis	Y	N	
Pregnancy	Y	N	
Sleep Apnea	Y	N	

Other: ______________________

Social History

Do you smoke? Y N How much? ______________

Do you drink alcohol? Y N How much? ______________

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other: ____		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other: ____		

Allergic / Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other: ____		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other: ____		

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Other: ____		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Other: ____		

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other: ____		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other: ____		

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other: ____		

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other: ____		

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other: ____		

Hematologic / Lymphatic

Swollen glands	Y	N
Blood Clotting problem	Y	N
Other: ____		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other: ____		

Genitourinary

Painful urination	Y	N
Bloody urination	Y	N
Urine retention	Y	N
Air in urine stream	Y	N
Urinary incontinence	Y	N

1. On average, about how many times a day do you urinate? ____ times a day.
2. On average, how many times during the night do you urinate? ____
3. During a typical day, how may protective pads do you wear?
   ____ diapers ____ maxi pads ____ panty liners
4. Do you leak urine at night in bed? ____ Yes ____ No
5. How often do you have such a strong urge to urinate that you expect leakage before you reach the toilet? ____ Often ____ Sometimes ____ Seldom ____ Never
   Do you ever actually experience leakage at these times? ____ Yes ____ No
6. How often do you leak urine when you sneeze, cough, laugh or exercise?
   ____ Often ____ Sometimes ____ Seldom ____ Never
7. Which causes most of your leakage? ____ above #5 ____ above #6
8. Do you have to strain to get a urine stream started? ____ Yes ____ No
9. Do you feel like you empty your bladder? ____ Yes ____ No
10. Have you ever had bladder or kidney infections? ____ Yes ____ No
11. How often do you experience pain or discomfort when you urinate?
    ____ Often ____ Sometimes ____ Seldom ____ Never
12. Have you ever had surgery to correct urinary incontinence? ____ Yes ____ No
13. How long have you had urinary incontinence? ____ Years ____ Months