



**SOCIAL HISTORY** Please ✓ and answer all questions

Do you use tobacco? Never\_\_\_ Presently\_\_\_ Quit (& date)\_\_\_\_\_

How many packs per day do/did you smoke? \_\_\_\_\_

How many total years have you/did you smoke(d)? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_drinks/week \_\_\_ Social \_\_\_ Never

Have you ever used recreational drugs? No\_\_\_ Yes\_\_\_

Occupation:\_\_\_\_\_ Retired? No\_\_\_ Yes\_\_\_

Please List your Daily Fluids (coffee/water/soda/alcohol, etc) and  
How much (cups/ounces): \_\_\_\_\_

What do you drink between dinner and bedtime, and how much?  
\_\_\_\_\_

**REVIEW OF SYSTEMS** Please ✓ all that apply

**Urinary Tract**

\_\_\_ Frequency of urination

Times per day\_\_\_\_\_

\_\_\_ Need to urinate at night

Times per night\_\_\_\_\_

\_\_\_ Sudden, strong urge to urinate

\_\_\_ Involuntary leakage of urine

Number of Pads per day \_\_\_\_\_

\_\_\_ Urine leakage before getting to the toilet

\_\_\_ Pain or burning with urination

\_\_\_ Bladder pain or pressure

\_\_\_ Blood in urine

\_\_\_ Difficulty getting flow started

\_\_\_ Slow, prolonged flow

\_\_\_ Straining to urinate

\_\_\_ Incomplete emptying of urine

\_\_\_ Bladder Infections

How many per year? \_\_\_\_\_

\_\_\_ Kidney Stones

Did you pass the stone? \_\_\_\_\_

Did you need surgery? \_\_\_\_\_

**Constitutional**

\_\_\_ Weight gain / loss

\_\_\_ Fever

\_\_\_ Chills

\_\_\_ Anorexia

\_\_\_ Fatigue

\_\_\_ Headaches

**Gastrointestinal**

\_\_\_ Abdominal Pain

\_\_\_ Nausea

\_\_\_ Vomiting

\_\_\_ Constipation

\_\_\_ Diarrhea

\_\_\_ Heartburn / Indigestion

\_\_\_ Bowel Accidents

**Hematological/Lymphatic**

\_\_\_ Enlarged lymph nodes

\_\_\_ Blood clotting problems

\_\_\_ Abnormal bruising

**Male Issues**

\_\_\_ Problems with erections

\_\_\_ No Interest in sex

\_\_\_ Ejaculation problems

\_\_\_ Painful erections

\_\_\_ Sore on genitals

\_\_\_ Discharge from penis

\_\_\_ Previous venereal disease

\_\_\_ Painful testicle

\_\_\_ Lump in testicle

\_\_\_ Foreskin problem

\_\_\_ Infertility Concern

**Eyes**

\_\_\_ Double Vision

\_\_\_ Blurred Vision

\_\_\_ Eye Pain

**Musculoskeletal**

\_\_\_ Back Pain

\_\_\_ Muscle Weakness

\_\_\_ Joint Pain / Stiffness

**Ears, Nose, Throat**

\_\_\_ Ear infection

\_\_\_ Sore Throat

\_\_\_ Sinus Problems

\_\_\_ Ringing in Ears

**Skin**

\_\_\_ Rashes

\_\_\_ Easy bruising

\_\_\_ Skin sores

**Cardiovascular**

\_\_\_ Chest Pain / Angina

\_\_\_ High Blood Pressure

\_\_\_ Irregular Heart Beat

\_\_\_ Previous Heart Attack

**Neurological**

\_\_\_ Weakness

\_\_\_ Numbness

\_\_\_ Tingling

\_\_\_ Dizziness

**Female Issues**

Last PAP Smear\_\_\_\_\_

Last Menstrual Period\_\_\_\_\_

\_\_\_ Post-Menopausal

\_\_\_ Irregular Periods

\_\_\_ Painful Intercourse

\_\_\_ Vaginal Dryness

Could you be Pregnant?

Yes\_\_\_ No\_\_\_ Unsure\_\_\_

How Many Children have you had?

Vaginal Deliveries\_\_\_\_\_

C-Sections\_\_\_\_\_

Miscarriages\_\_\_\_\_

**Respiratory**

\_\_\_ Shortness of Breath

\_\_\_ Wheezing

\_\_\_ Cough

\_\_\_ Asthma

**Psychiatric**

\_\_\_ Anxiety

\_\_\_ Depression

\_\_\_ Memory loss

\_\_\_ Alcohol / Drug addiction

**The Above Information is Correct.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

NOTES: (For Office Use Only)