

Circle Y or N to all illnesses/conditions that apply to you now or in the past			
Illness	Currently	Previously	Explain or describe
Cancer(type_____)	Y N	Y N	
Depression	Y N	Y N	
Diabetes	Y N	Y N	
Heart Disease	Y N	Y N	
Hepatitis	Y N	Y N	
High Blood Pressure	Y N	Y N	
High Cholesterol	Y N	Y N	
Kidney Disease/Stones	Y N	Y N	
Thyroid Disease	Y N	Y N	
Vascular Disease/Blood clots	Y N	Y N	
Other medical illnesses:			

What is your height:_____ and approximate weight:_____

Do you take antibiotics before going to the dentist? Yes / No. If Yes, why_____

Surgical History		
Operation	Month/Year	Where was the surgery done

Family History		
Has anyone in your family had problems with:	If Yes, parent, sibling, grandparent, or other	
Infertility	Y N	
Heart Disease	Y N	
Kidney Stones	Y N	
Prostate Cancer	Y N	
Urologic/gynecologic cancers	Y N	

Social History
Do you smoke? Yes/ No ; Packs/day_____ ; Years smoked _____ ; Quit in _____
Do you drink? Yes/ No. If yes, Number of drinks per day_____ per week_____
Do you exercise regularly? Yes or No. If yes, type & frequency of activity_____
Occupation_____

Patient Name : _____

Today's Date: _____

MD Initials _____ Date _____

Please list your current medications below:			
Medications & Dosage	Frequency	Medications & Dosage	Frequency

Allergies to any medications:
 Name & Reaction _____
 Name & Reaction _____
 Have you ever had an allergic reaction to iodine/ shellfish / Imaging contrast? YES/ NO
 If yes describe your reaction _____
 Are you allergic to LATEX? YES / NO (If yes, describe your reaction) _____

Do you now or have you had problems related to the following systems? Circle Y or N

General Health

Fever Y / N Chills Y / N

Eyes

Blindness Y / N Eye Pain Y / N

Ear/Nose/Throat/Mouth

Frequent Nosebleeds Y / N Deafness Y / N

Respiratory

Shortness of Breath Y / N Frequent Cough Y / N

Gastrointestinal

Nausea/Vomiting Y / N Constipation Y / N

Genitourinary

Blood in Urine Y / N Painful urination Y / N

Musculoskeletal

Back pain Y / N Neck pain Y / N

Neurologic

Numbness Y / N Tingling Y / N

Cardiovascular

Palpitations Y / N Chest pain Y / N

Hematologic/Lymphatic

Blood clotting problem Y / N Swollen glands Y / N

Extremities

Need Walker/Wheelchair Y / N Swelling Y / N

Patient Name : _____

Today's Date: _____

MD Initials _____ Date _____