MEDICAL HISTORY

PATIENT NAME_____**DOB**_____

REASON FOR VISIT

_____

_____

CURRENT MEDICATIONS (Includes Vitamins, Herbal Supplements, and Over the Counter Medicines)

Medication	Dosage	Medication	Dosage
If you need more space please list on the reverse side.			

ALLERGIES_____

HEIGHT_____**WEIGHT**_____

ANY FAMILY HISTORY OF KIDNEY STONES OR CANCER

_____

_____

Personal Medical History (check all that apply)

☐ Anemia	☐ Asthma, Emphysema	☐ UTI	☐ Erection Problems	☐ Prostate Cancer
☐ Cancer	☐ Bladder/Kidney Infections	☐ Hepatitis	☐ Blood Clots	☐ Kidney Stones
☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Bleeding Problems	☐ Incontinence
☐ Stroke	☐ Blood in Urine/Stool	☐ Pregnancies	☐ Urination Problems	☐ Gastrointestinal

PAST SURGICAL HISTORY

_____

PNEUMOCOCCAL AND INFLUENZA VACCINE:

☐ I HAVE ☐ I HAVE NOT HAD THE PNEUMOCOCCAL VACCINE. WHEN_____

☐ I HAVE ☐ I HAVE NOT HAD THE INFLUENZA IMMUNIZATION WHEN_____