LAU PATIENT HEALTH FORM

Name_____ Date_____

DOB_____ Age____ Ht._____ Wt. _____ Referring Physician_____

What is the chief reason for your visit? _____

YOUR MEDICAL HISTORY SYSTEM REVIEW

Please check any of the following medical problems that currently apply to you:

Respiratory
- Wheezing ___
- Bronchitis ___
- Shortness of breath ___
- Labored breathing ___

Allergic/Immunologic
- Hay fever ___
- Drug allergies ___
- Skin rashes or itching ___
- Asthma ___

Neurological
- Tremors or seizures ___
- Dizzy/fainting spells ___
- Numbness/tingling ___
- Headaches ___
- Double vision ___

Gastrointestinal
- Abdominal pain ___
- Nausea ___
- Indigestion/heartburn___
- Diarrhea ___
- Constipation ___

Hematological
- Swollen glands ___
- Bleeding problems ___
- Sweats ___
- Easy bruising ___
- Anemia ___

Endocrine
- Excessive thirst ___
- Heat intolerance ___
- Tired/sluggish ___
- Excessive hair loss ___

Musculoskeletal
- Arthritis ___
- Painful,swollen joints ___
- Sore/achy muscles ___
- Gout ___

Constitutional
- Fever ___
- Chills ___
- Weight change ___
- Frequent Infections ___
- Menstrual dysfunction ___

Psychiatric
- insomnia ___
- Depression ___
- Poor memory ___
- Anxiety ___
- Substance Abuse ___

Genitourinary
- Urine retention ___
- Painful urination ___
- Urinary frequency ___
- Incontinence ___
- Blood in the urine ___

Cardiovascular
- Heart palpitations ___
- Blackout spells ___
- Chest pain ___
- Edema ___
- Leg pain with walking ___

Ear, Nose, Throat
- Visual disturbance ___
- Nose Bleeds ___
- Nasal Congestion ___
- Difficulty swallowing ___

DO YOU HAVE:

_____DIABETES

_____KIDNEY DISEASE

_____HYPERTENSION

INFORMATION UPDATED

AUA/IPPS SCORE	DATE

PROBLEM LIST	DATE

Date	P	T	BP

LAU PATIENT HEALTH FORM
Please check all that apply:

SOCIAL HISTORY

Smoker? Y ___N___ quit_____
Packs Daily_____How Long?_____
Alcohol: drinks/week _____
Education: _____
Occupation: _____
Special Diet: _____

Please List Vitamins, Herbal drugs, OTC Drugs:

_____

_____

Daily Aspirin Use Y__ N__

PARENT HISTORY

Mother alive___Deceased___ age____
Cause of Death_____
Father alive___Deceased___ age____
Cause of Death_____

FAMILY HISTORY

	Father	Mother	Sibling	Children
Heart Disease	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑
Stroke	❑	❑	❑	❑
Prostate cancer	❑	❑	❑	❑
Colon polyps	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑
Kidney Stones	❑	❑	❑	❑
Anesthesia Problems	❑	❑	❑	❑

YOUR PERSONAL PAST MEDICAL HISTORY

Year or Age **Hospitalization / Surgery / Major Trauma / Illnesses**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES (Medications, Latex, X-Ray dye, Other)
Type of Reaction (Rash, Hives, Black out)

_____
_____
_____

MEDICATIONS (or List)

DATE MEDICATION DOSAGE **DATE MEDICATION DOSAGE**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____