DALE R. TRAFICANTE, M.D., F.A.C.S.

UROLOGY

Board Certified Urologist

PATIENT HISTORY

Date _____

Last Name _____ First Name _____ Middle Initial _____

Age _____ Sex _____ Height _____ Weight _____

Chief Complaint (reason for today's visit) _____

HISTORY OF PRESENT ILLNESS

Location of Problem _____ Severity of Problem (scale of 1-10 with 10 being the most severe) _____

When did you first notice the problem? _____

Does anything help/worsen the problem? _____ How long does the problem last? _____

Does anything else occur at the same time? (If yes, please explain)

_____

Is the problem constant or variable? _____ Does it interfere with your quality of life? Y ◯ N ◯

MEDICAL HISTORY (Please Check)

Arthritis ☐	Depression ☐	Hypothyroid ☐	Hypertension ☐
Asthma ☐	Diabetes ☐	Glaucoma ☐	Stroke ☐
Cancer ☐	Lung Disease ☐	Heart Disease ☐	Anesthesia Allergy ☐

Other Problems _____

OB/GYN HISTORY (Female Patients)

Menarche Age ____	Menopause Age ____	No. of Pregnancies ____
Vaginal Deliveries ____	C-Sections ____	

SURGICAL HISTORY (List any surgical procedure you have had in the past)

_____

_____

MEDICATIONS (List any current medications or supplements along with dosage)

_____

_____

ALLERGIES (List any medications that you are allergic to)

_____

_____

SOCIAL HISTORY

Marital Status: Married ☐ Single ☐ Widow ☐ Occupation: _____

Do you smoke? Y ◯ N ◯ How many per day? _____ For how many years? _____

Have you ever smoked? Y ◯ N ◯ For how long? _____ When did you quit? _____

Other Tobacco use _____

Do you drink? Y ◯ N ◯ How many drinks per week? _____ For how long? _____

Have you ever had a problem with alcohol abuse? Y ◯ N ◯ History of illicit drug use? Y ◯ N ◯

Do you exercise regularly? Y ◯ N ◯ How often?

FAMILY HISTORY (Check the appropriate blank if anyone in your immediate family has had any of the following)

Cancer ☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Strokes ☐

Unusual Diseases _____

REVIEW OF SYSTEMS (Do you now or have you had any problems related to the following systems?) Please check

Constitutional Symptons
Fever ☐
Chills ☐
Headache ☐
Other _____

Eyes
Blurred Vision ☐
Double Vision ☐
Pain ☐
Other _____

Allergic/Immunologic
Hay Fever ☐
Drug Allergies ☐
Other _____

Neurological
Tremors ☐
Dizzy Spells ☐
Numbness/Tingling ☐
Other _____

Endocrine
Excessive Thirst ☐
Too Hot/Cold ☐
Tired/Sluggish ☐
Other _____

Gastrointestinal
Abdominal Pain ☐
Nausea/Vomiting ☐
Indigestion/Heartburn ☐
Other _____

Cardiovascular
Chest Pain ☐
Varicose Veins ☐
High Blood Pressure ☐
Other _____

Integumentary
Skin Rash ☐
Boils ☐
Persistent Itch ☐
Other _____

Musculoskeletal
Joint Pain ☐
Neck Pain ☐
Back Pain ☐
Other _____

Ear/Nose/Throat/Mouth
Ear Infection ☐
Sore Throat ☐
Sinus Problems ☐
Other _____

Genitourinary
Urine Retention ☐
Painful Urination ☐
Urinary Frequency ☐
Other _____

Respiratory
Wheezing ☐
Frequent Cough ☐
Shortness of Breath ☐
Other _____

Hematologic/Lymphatic
Swollen Glands ☐
Blood Clotting Problems ☐
Other _____

Psychologic
Are you generally satisfied with your life? ☐
Do you feel severely depressed? ☐
Have you considered suicide? ☐
Other _____

Who do you give permission for the office to speak to regarding your condition? _____

_____

H&P REVIEWED BY:

_____

Dale R. Traficante, MD, FACS