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? _______

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 _____ Divorced _____ Widow ______ Occupation: _____________

Do you smoke? ____________ How many per day? _____________ For how many years? ________

Have you ever smoked? ______ For how long? __________________ When did you quit? __________

Other Tobacco use? ________________________

Do you drink? _____ How many drinks per week? _______ For how long? ________________________

Have you ever had a problem with alcohol abuse? ______ History of illicit drug use? _______________

Do you exercise regularly? ______ 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 _______ Unusual Diseases ______________ Strokes _____________

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

Constitutional Symptons
Fever Y N
Chills Y N
Headache Y N
Other __________________

Eyes
Blurred Vision Y N
Double Vision Y N
Pain Y N
Other ______________________

Allergic/Immunologic
Hay Fever Y N
Drug Allergies Y N
Other ______________________

Neurological
Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other __________________

Endocrine
Excessive Thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Other ______________________

Gastrointestinal
Abdominal Pain Y N
Nausea/Vomiting Y N
Indigestion/Heartburn Y N
Other ______________________

Cardiovascular
Chest Pain Y N
Varicose Veins Y N
High Blood Pressure Y N
Other __________________

Integumentary
Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other ______________________

Musculoskeletal
Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other ______________________

Ear/Nose/Throat/Mouth
Ear Infection Y N
Sore Throat Y N
Sinus Problems Y N
Other __________________

Genitourinary
Urine Retention Y N
Painful Urination Y N
Urinary Frequency Y N
Other _______________________

Respiratory
Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other ______________________

Hematologic/Lymphatic
Swollen Glands Y N
Blood Clotting Problems
Y N
Other __________________

Psychologic
Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other _______________________

Who do you give permission for the office to speak to regarding your condition? ______________________
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Dale R. Traficante, M.D., P.A.