Established Patient Medical Update

Date: _____/_____/_____ Phone: (_____)_____ Cell Phone: (_____)_____

Patient Name:_____ DOB: _____/_____/_____ Sex: ☐ M ☐ F

Ref / PC Physician:_____ Pharmacy: _____ Phone:_____

Allergies:_____

Please answer the following questions about your personal <u>past</u> medical history:

<u>Cardio-vascular:</u>

☐ Heart attack ☐ High blood pressure ☐ Heart valve problems ☐ Irregular heart beat ☐ Coronary artery disease
☐ Heart murmur ☐ Deep Vein Thrombosis ☐ Anemia ☐ Bleeding tendency ☐ Congestive heart failure

<u>Endocrine:</u>

☐ Insulin dependent ☐ Diabetes/diet ☐ <u>HYPER</u>thyroid ☐ <u>HYPO</u>thyroid ☐ Gout disease

<u>GI:</u>

☐ Acid reflux ☐ Irritable bowels ☐ Peptic Ulcers ☐ Diverticulitis ☐ Constipation/diarrhea

<u>GU:</u>

☐ Kidney stones ☐ Bladder stones ☐ Frequent UTI's ☐ BPH ☐ Prostatitis
☐ Bloody urine ☐ Erectile dysfunction ☐ Elevated PSA ☐ Incontinence ☐ Overactive bladder

<u>HEENT</u>:

☐ Glaucoma ☐ Cataracts ☐ Hayfever ☐ Vertigo ☐ Ear Infection

<u>Musculo-skeletal:</u>

☐ Arthritis ☐ Low Back Pain ☐ Fibromyalgea ☐ Joint replaced:_____

<u>Neurologic:</u>

☐ Stroke ☐ Migraines ☐ Parkinson's ☐ Chronic headaches ☐ Multiple Sclerosis
☐ Seizures ☐ Polio ☐ Spinal cord injury ☐ Spina bifida ☐ Unsteady gait

<u>Pulmonary:</u>

☐ Emphysema ☐ Asthma ☐ Bronchitis ☐ COPD ☐ Lung Cancer

<u>Hematology/Oncology:</u>

☐ Prostate cancer ☐ Bladder cancer ☐ Kidney cancer ☐ Testicle cancer ☐ Colorectal cancer
☐ Uterine cancer ☐ Lymphoma ☐ Leukemia ☐ Ovarian cancer ☐ Other:_____

PAST SURGERIES:

☐ Heart Surgery ☐ Gall Bladder ☐ Colon Resection ☐ Hernia ☐ Kidney Stones ☐ Nephrectomy
☐ Hysterectomy ☐ Thyroid ☐ Hip / Knee / Back ☐ Lung ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma
☐ Other:_____

FAMILY MEDICAL HISTORY:

Father or Mother families or Sibling having any of the following?

Prostate Cancer	Y	N	Father,	Mother,	Sibling
Kidney Cancer	Y	N	Father,	Mother,	Sibling
Bladder Cancer	Y	N	Father,	Mother,	Sibling
Colon Cancer	Y	N	Father,	Mother,	Sibling
Bleeding Disorder	Y	N	Father,	Mother,	Sibling
Polycystic Kidneys	Y	N	Father,	Mother,	Sibling
Kidney Failure	Y	N	Father,	Mother,	Sibling
Kidney or Bladder Stones	Y	N	Father,	Mother,	Sibling
Urinary Tract Infections	Y	N	Father,	Mother,	Sibling
Interstital Cystitis	Y	N	Father,	Mother,	Sibling

MEDICATIONS (LIST NAME & DOSAGE):

_____

_____

_____

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I hereby authorize consent for treatment and release of any necessary information acquired in the course of examination and treatment by my physician for processing of my medical claim.

Signature of
Patient / Insured / Legal Guardian:_____ **Date:**_____