Merrimack Urology Associates

Complete connected care℠

MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____/_____/_____

Signature: _____ Date: _____/_____/_____

Present Health Concerns: _____

MEDICATIONS: *Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

***** If you are on 3 or more medications – please bring them with you to each appointment. *****

PERSONAL MEDICAL HISTORY: *Please indicate whether you have had any of the following medical problems.*

___Congenital Heart Disease:
please specify: _____
___Myocardial Infarction (Heart Attack)
___Hypertension (High Blood Pressure)
___Coronary Heart Disease
___High Cholesterol or Lipids

___Cancer (Malignancy)
please specify: _____
___Ulcerative Colitis
___Bleeding Disorder
___Spinal Disc Disease
___Atrial Fibrillation

___Kidney Insufficiency
___Kidney Failure: on Dialysis
___Thyroid Disease
___ Ulcerative Colitis
___ Peripheral Artery Disease
___Crohn's Disease

___Stroke
___Diabetes
___Asthma
___COPD
___Glaucoma
___Gastric Reflux
Other: _____
_____

FAMILY HISTORY: *Please indicate with a check* (√) *who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer (Type)	Mental Illness	Other
Mother								
Father								
Children								
Siblings								
Has any other blood relative had the following above?								

SOCIAL HISTORY:

Exercise:
Do you exercise regularly? □ Yes □ No

Tobacco Use:
□ Current □ Never □ Former, quit on: _____
If current # of packs/day ___ # of years _____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes

Drug Use:
Do you use any recreational drugs?
□ Yes □ No
If yes please list _____
If you have used in the past, how long have you been drug free? _____
Have you ever used needles for IV Drug Use?
□ Yes □ No

Alcohol Use
Do you drink alcohol? □ Yes □ No
If yes, # of drinks per week: _____
What type of alcohol: _____
Is alcohol a concern for you or others who surround themselves around you?
□ Yes □ No

REVIEW OF SYSTEMS: Please indicate with a check (√) any current problems you have below

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Weakness

Female Reproductive
- ☐ Vaginal discharge
- ☐ Pelvic pain

Male Reproductive
- ☐ Erectile dysfunction
- ☐ Low sex drive

Respiratory
- ☐ Cough
- ☐ Shortness of breath

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations

Gastrointestinal
- ☐ Blood in bowel movement
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Bone pain

Skin
- ☐ Persistent itching
- ☐ Skin rash

Ears/Nose/Throat/Mouth
- ☐ Bloody nose
- ☐ Ringing in ears
- ☐ Sinus pain
- ☐ Blurred Vision

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Discharge from penis

Neurological
- ☐ Headaches
- ☐ Insomnia
- ☐ Memory loss
- ☐ Neuropathy

Other Issues: _____
_____
_____
_____

Endocrine
- ☐ Excessive thirst
- ☐ Dry mouth

Hematologic
- ☐ Easy bruising
- ☐ Swollen glands

Psychiatric
- ☐ Anxiety/stress
- ☐ Depression
- ☐ High stress level

SURGICAL HISTORY: Please indicate with a check (√) any current problems you have below

- ☐ Heart or Valve Surgery
- ☐ Cardiac Stents
- ☐ Vascular Surgery or Stents
- ☐ Head/Neck or Brain Surgery
- ☐ Abdominal Surgery
- ☐ Gallbladder
- ☐ Hernia
- ☐ Kidney Surgery
- ☐ Kidney Stone Procedures
- ☐ Orthopedic Surgery
- ☐ Artificial joints or implants
  - ☐ Hips
  - ☐ Knees
- ☐ Other: _____
_____
_____

Reset Form