Print Form Clear Form

LOURDES	Patient History	John W. Miller, M.D. James R. Steinmetz, M.D. Peter E. Lethin, M.D. Jennifer MaLossi, M.D.

Note: This is a confidential record and will be kept in your doctor's office. Information here will not be released to anyone without your authorization.

Today's Date: _____

Patient's Full Name:_____ DOB: _____

Chief Complaint – What is the reason for your visit today? (Describe your problem in detail.)

_____

_____

_____

History of Present Illness

Location of the problem:
☐ Abdomen ☐ Back ☐ Groin
☐ Other: _____
_____
_____

On a scale of 1 -10 (10 being most severe), circle the number that best describes the problem.
1 2 3 4 5 6 7 8 9 10

How long have you be experiencing the problem?
Days _____ Weeks _____ Months _____

How long does the problem last?
☐ 30 Minutes ☐ 1 Hour ☐ Always There

Is there anything else occurring at the same time?
☐ No ☐ Yes (please explain.)
_____
_____
_____

Is the problem ☐ constant or ☐ variable?
☐ Dull then Sharp ☐ Sharp ☐ Burning
☐ Intermittent

Does the problem interfere with your normal function?
☐ No ☐ Yes (please explain.)
_____
_____
_____

Does anything make the problem worse?
☐ No ☐ Yes (please explain.)
_____
_____
_____

Does anything make the problem better?
☐ No ☐ Yes (please explain.)
_____
_____
_____

Physician Use Only (Comments/Notes)

Past Medical & Social History

Family History

Father: Age: _____ Significant Medical Illnesses: _____

_____

Mother: Age: _____ Significant Medical Illnesses: _____

_____

Your Previous Surgeries: _____

_____

Are you on any medications? ☐ No ☐ Yes (please list.) _____

_____

_____

Do you have any allergies? ☐ No ☐ Yes (please list.) _____

_____

_____

Do you smoke? ☐ No ☐ Yes How much? _____

Do you drink alcohol? ☐ No ☐ Yes How much? _____

Physician Use Only (Comments/Notes)

Voiding history (circle positives): Hematuria: _____; hesitancy force of stream: _____ ; sensation of incomplete emptying
Nocturia: _____ ; end stream dribbling UTI; Calculi; Incontinence – Urge / Stress

Review of systems

Do you now or have you had any problems related to the following systems? (Please explain.)

Constitutional Symptoms
Fever ☐ No ☐ Yes
Chills ☐ No ☐ Yes
Headache ☐ No ☐ Yes
Other_____

Eyes
Blurred Vision ☐ No ☐ Yes
Double Vision ☐ No ☐ Yes
Pain ☐ No ☐ Yes
Other_____

Allergic/Immunologic
Hay Fever ☐ No ☐ Yes
Drug Allergies ☐ No ☐ Yes
Other_____

Neurological
Tremors ☐ No ☐ Yes
Dizzy Spells ☐ No ☐ Yes
Numbness/ Tingling ☐ No ☐ Yes
Other_____

Endocrine
Excessive Thirst ☐ No ☐ Yes
Too Hot/Cold ☐ No ☐ Yes
Tired/Sluggish ☐ No ☐ Yes
Other_____ ____

Gastrointestinal
Abdominal Pain ☐ No ☐ Yes
Nausea/Vomiting ☐ No ☐ Yes
Indigestion/ Heartburn ☐ No ☐ Yes
Other_____

Cardiovascular
Chest Pain ☐ No ☐ Yes
Varicose Veins ☐ No ☐ Yes
High Blood Pressure ☐ No ☐ Yes
Other_____

Integumentary
Skin Rash ☐ No ☐ Yes
Boils ☐ No ☐ Yes
Persistent Itch ☐ No ☐ Yes
Other _____

Musculoskeletal
Join Pain ☐ No ☐ Yes
Neck Pain ☐ No ☐ Yes
Back Pain ☐ No ☐ Yes
Other _____

Ear / Nose / Throat / Mouth
Ear Infection ☐ No ☐ Yes
Sore Throat ☐ No ☐ Yes
Sinus Problems ☐ No ☐ Yes
Other _____

Genitourinary
Urine Retention ☐ No ☐ Yes
Painful Urine ☐ No ☐ Yes
Urinary Frequency ☐ No ☐ Yes
Other _____

Respiratory
Wheezing ☐ No ☐ Yes
Frequent Cough ☐ No ☐ Yes
Shortness of Breath ☐ No ☐ Yes
Other _____

Hematologic Lymphatic
Swollen Glands ☐ No ☐ Yes
Blood Clotting Problem ☐ No ☐ Yes
Other _____

Psychological
Are you generally satisfied with your life? ☐ No ☐ Yes
Do you feel severely depressed? ☐ No ☐ Yes
Have you considered suicide? ☐ No ☐ Yes
Other _____

Physician Use Only (Comments/Notes)

#Answer	Level of Service
0 – 1	1 or 2
2 – 9	3
10+	4 or 5

Physician: _____ Date:_____