KCUC

Patient History Form for Use with EMR

This is a confidential record and will be kept in your electronic patient chart. Information contained here will not be released to anyone without your authorization.

TODAY'S DATE _____ / _____ / _____ **DATE OF BIRTH** _____ / _____ / _____

LAST NAME _____ **FIRST NAME** _____ **M.I.** ___

Reason for seeing the physician on the first visit: _____

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

LIST CURRENT MEDICATIONS *(include over the counter items such as aspirin)*

MEDICATION/DOSAGE	MEDICATION/DOSAGE
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

OVER-THE-COUNTER SUPPLEMENT MEDICATIONS

_____ _____ _____ _____ _____

Are you required to take antibiotics with dental work? N Y

PAST SURGICAL HISTORY – Check previous surgeries & provide date ***(if nothing marked then NONE APPLY)***

__Bladder augmentation_____
__Bladder suspension_____
__Cystectomy_____
__Cystoscopy_____
__Green light PVP_____
__Hydrocele repair_____
__Kidney Stone Removal_____
__Laparoscopy_____
List type of Laparoscopy
__Lithotripsy_____
__Nephrectomy_____
__Pacemaker_____
__Percutaneous nephrolithotomy_____
__Pubovaginal sling_____
__Tubal ligation_____
__Ureteroscopy-stent_____
__Vasectomy_____
__Other_____

__Adrenalectomy_____
__Appendectomy_____
__Back surgery_____
__Breast biopsy_____
__CABG_____
__Cesarean section_____
__Cholecystectomy_____
__Colon surgery_____
__ Colonoscopy _____
__Coronary Stent_____
__Gastric bypass_____
__Heart Valve Replacement_____
__Hernia repair_____
__Hip replacement_____
__Hysterectomy_____
__Knee replacement_____
__Mastectomy_____
__Other_____

Last Name _____ First Name _____ DOB _____

PAST MEDICAL HISTORY – Check any previous past medical problems *(if nothing marked then NONE APPLY)*

___ Anemia
___ Angina (Chest Pain)
___ Arthritis
___ Asthma
___ BPH
___ Cancer_____
List type of cancer
___ CVA (Stroke)
___ Chronic UTIs
___ Congestive heart failure
___ COPD
___ Coronary artery disease
___ Depression
___ Diabetes 1 OR 2 (circle one)
___ Diverticular disease
___ GERD (Gastric Reflux)
___ Gout
___ Hepatitis C
___ High Cholesterol
___ Hyperlipidemia
___ High Blood Pressure
___ Hypothyroid
___ Inflammatory bowel disease
___ Liver disease
___ Lupus
___ Migraine headaches
___ Multiple Sclerosis
___MI (Heart Attack)
___ Osteoarthritis
___ Osteoporosis
___Peptic Ulcer Disease
___Peripheral Vascular Disease
___ Renal Disease
___ Dialysis
(___Hemo ___Peritoneal)
___ Rheumatoid Arthritis
___ Seizure Disorder
___ Urolithiasis (Kidney Stones)
Other_____ Other_____

FAMILY HISTORY Indicate what family member has the condition (FATH, MOTH, SIS, BRO, DAU, SON)

Anesthesia Problems _____ Colon Cancer _____ Kidney Stones _____ Pancreatic Cancer _____
Bladder Cancer _____ Gastric Cancer _____ Melanoma _____ Prostate Cancer _____
Bleeding Disorders _____ Kidney Cancer _____ Metastatic Prostate Ca _____ Testicular Cancer _____
Breast Cancer _____ Kidney Disease_____ Ovarian Cancer _____ Uterine Cancer _____
Other Cancer (specify) _____

SOCIAL HISTORY: Please Circle Answers

Smoking Status: (please circle) Current Smoker Previous Smoker
Began in year _____ Quit in year_____ Never Smoked

Do you use Smokeless Tobacco? (please circle) Yes No

How many caffeinated drinks do you have each day? (please circle) 0 1 2 3 4+

Do you drink alcohol? (please circle) Yes Not Anymore Never Drank

Drinking habits? (please circle) Social Light Moderate Excessive

Do you use recreational drugs? (please circle) Yes No If yes, what type? _____

Have you had a blood transfusion? (please circle) Yes No

Sexually Active? (please circle) Yes No Not Currently **Partners?** (please circle) Female Male Both

Approximate Height: _____ **Weight:** _____

Current/Former Occupation? _____