

Medical History
Circle Y or N for every Question

Diabetes	Y	N	Smoking	Y	N
High Blood Pressure	Y	N	How much (packs/day) _____		
Stroke	Y	N	Drinking (alcohol)	Y	N
Kidney Stones	Y	N	How much		
Kidney Failure/Dialysis	Y	N	Other _____		
Heart Disease	Y	N	_____		
Incontinence	Y	N	_____		
Urinary Tract Infections	Y	N	_____		
Artif. Joint or Heart Valves	Y	N	_____		
Cancer (list type and date)	Y	N	_____		

Surgical History
List any surgical procedures with approximate date

Systems Review
Circle Y or N for every Question

Fever	Y	N	Tremors	Y	N	Excessive Thirst	Y	N
Chills	Y	N	Seizures	Y	N	Abdominal Pain	Y	N
Headache	Y	N	Chest Pain	Y	N	Nausea / Vomiting	Y	N
Weight Loss	Y	N	Wheezing	Y	N	Indigestion / Heartburn	Y	N
Hay Fever	Y	N	Frequent Cough	Y	N	Blood in Stool	Y	N
Sinus Problems	Y	N	Shortness of Breath	Y	N	Skin Rash	Y	N
Bleeding Problems	Y	N	Blood in Sputum	Y	N	Glaucoma	Y	N

Family History
Circle Y or N for any blood relatives affected

Diabetes	Y	N	Prostate Cancer	Y	N
Bleeding Problems	Y	N	Kidney Cancer	Y	N
Heart Disease	Y	N	Bladder Cancer	Y	N
Kidney Stones	Y	N	Other Cancer (list) _____		

Name: _____ Date: _____