MEDICAL HISTORY

Current Date _____ Name _____ DOB _____

Primary Care Practitioner _____

☐ No **Heart Problems**

		Notes
High Blood Pressure	☐ Yes	
Heart Attack-Last 6 Months	☐ Yes	
Chest Pain-Last 6 Months	☐ Yes	
Pacemaker/Defibrillator	☐ Yes	
Other	☐ Yes	

☐ No **Lung Problems**

COPD/Emphysema	☐ Yes	
Asthma	☐ Yes	
Sleep Apnea	☐ Yes	
Recent Pneumonia	☐ Yes	
Smoking	☐ Yes	☐ Quit

☐ No **Neurological Problems**

Stroke or TIA	☐ Yes	
Deficits?	☐ Yes	
☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair		
Multiple Sclerosis	☐ Yes	
Dementia	☐ Yes	
Mental Illness	☐ Yes	
Seizure disorder	☐ Yes	
DBS/Cochlear Device	☐ Yes	
Other	☐ Yes	

☐ No **Gastrointestinal Problems**

Reflux	☐ Yes	
Alcohol use	☐ Yes	

☐ No **Metabolic Problems**

Diabetes ☐ Type I ☐ Type II		
A1C BG		
Renal failure/dialysis	☐ Yes	

☐ No **Other Problems**

Autoimmune disease	☐ Yes	
Cancer	☐ Yes	
HIV, Hepatitis A/B/C	☐ Yes	
Any Current Active Infection	☐ Yes	
On Blood Thinners?	☐ Yes	INR:
Fever	☐ Yes	
Hearing Aids?	☐ Yes	
Other:	☐ Yes	

☐ No **Prostate-like medications used**

Tamsulosin (Flomax/Jalyn)	☐ Yes	
Terazosin	☐ Yes	
Doxazosin	☐ Yes	
Alfuzosin	☐ Yes	
Silodosin	☐ Yes	
Saw Palmetto	☐ Yes	
SEE ATTACHED MEDICATION LIST		

COVID-19 Screening

Travel	☐ No	
Symptoms	☐ No	
Exposure	☐ No	

Drug Allergies/Reactions ☐ NKDA

1.
2.
3.
4.
5.

List Recent Major Surgeries - Last 6 Months

1.
2.
3.

Anesthesia Complications

☐ No ☐ Yes

Are you, or could you be pregnant

◉ No ○ Yes ○ Unknown

Office Use

Ht	Wt	BMI

Date	PSC Init.	MD

Patient Information