esse HEALTH
We Want You Well.

Patient Name: _____

Date: _____

Main Reason for Your Visit: _____

Medication List (Including over the counter medications): _____

_____

Allergy to Medications: _____

Reaction: _____

PAST MEDICAL HISTORY

DIABETES	YES	NO	EMPHYSEMA/COPD	YES	NO
HIGH BLOOD PRESSURE	YES	NO	PNEUMONIA	YES	NO
STROKES	YES	NO	DEPRESSION/BIPOLAR	YES	NO
HEART DISEASE/HEART ATTACK	YES	NO	MENTAL ILLNESS	YES	NO
KIDNEY STONES	YES	NO	DEMENTIA/ALZHEIMER'S ETC.	YES	NO
THYROID DISEASE	YES	NO	ULCER	YES	NO
SEIZURES	YES	NO	LIVER DISEASE	YES	NO
BLEEDING DISORDER	YES	NO	HIGH CHOLESTEROL	YES	NO
SEXUALLY TRANSMITTED DISEASE	YES	NO	IRRITABLE BOWEL SYNDROME	YES	NO
TUBERCULOSIS	YES	NO	GLAUCOMA (narrow angle) (wide angle)	YES	NO
RHEUMATIC FEVER	YES	NO	DIABETES	YES	NO
ASTHMA	YES	NO	CANCER	YES	NO
ANXIETY	YES	NO	~CANCER TYPE _____	YES	NO

PAST SURGICAL HISTORY

Heart Bypass Inguinal Hernia: Left Right Both Umbilical Hernia Repair	Appendectomy Gallbladder: Open Laparoscopic Vasectomy	Hysterectomy Abdominal Vaginal Ovaries Removed: Left Right Both
Joint Replacement(s):		

FAMILY HISTORY: ***(Please circle Medical Problems that run in your family)*** NONE PROSTATE CANCER BLADDER CANCER KIDNEY CANCER KIDNEY STONES HEART DISEASE DIABETES STROKES

OTHER: _____

_____

PATIENT SOCIAL HISTORY

USE OF TOBACCO: ☐Never ☐ Quit/Year: _____ ☐Yes, Packs/Day: ____ Other: _____

RECREATIONAL DRUG USE: ☐Never ☐Quit ☐Yes, Type & Frequency: _____

MARITAL STATUS: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

USE OF ALCOHOL: ☐Never ☐Quit ☐Rarely ☐Occasionally ☐Moderate ☐Heavy Amount: _____

OCCUPATION: ☐Full-time ☐Part-time ☐Retired ☐Disabled Job Description: _____

REVIEW OF SYSTEMS

FEVER/CHILLS/NIGHT SWEATS	YES	NO	HEARTBURN/DIFFICULTY SWALLOWING	YES	NO
DIZZY LIGHTHEADED	YES	NO	ABDOMINAL DISCOMFORT	YES	NO
WEIGHT CHANGE	YES	NO	NAUSEA/VOMITING	YES	NO
ALLERGIES/COLD SYMPTOMS	YES	NO	BLOODY/BLACK STOOLS	YES	NO
VISUAL PROBLEMS	YES	NO	RASHES	YES	NO
HEADACHES	YES	NO	HEARTBURN/DIFFICULTY SWALLOWING	YES	NO
NECK/BACK PAIN	YES	NO	URINARY PROBLEMS	YES	NO
COUGH	YES	NO	VAGINAL/PENILE DISCHARGE	YES	NO
SHORTNESS OF BREATH	YES	NO	INCREASED THIRST/URINATION	YES	NO
CHEST DISCOMFORT	YES	NO	DEPRESSION/ANXIETY	YES	NO
PALPITATIONS	YES	NO	INSOMNIA	YES	NO

HISTORY OF PRESENT ILLNESS *(Please circle and/or answer the following questions)*

Location of the problem:
Abdomen Back Leg Other: _____

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

When did you first notice the problem?
_____ days ago _____ weeks ago _____ month(s) ago
Other: _____

Is there anything else occurring at the same time?
YES NO If yes, please explain.
Nausea Vomiting Fevers Chills Headaches Rash
Other: _____

Can you qualify your problem/pain?
Dull then sharp Very sharp then leaves Always there
Other: _____

Does the problem interfere with your normal activity/functions?
YES NO If yes, please explain. _____

Please circle YES or NO to the following Questions:

YES NO Pain or burning with urination?
YES NO Blood in urine at any time?
YES NO Difficulty starting urination?
YES NO Inability to hold urine (Incontinence)?
YES NO Kidney/Bladder Infection?
YES NO Kidney Stones?
YES NO Bedwetting?
YES NO Urinating too frequently?
YES NO Awakening at night to urinate more than once?
If yes, how many times? _____
YES NO Have you been to a urologist before?
Name: _____ When: _____
YES NO Have you had bladder or kidney x-rays before?
YES NO NA Are your periods normal?
YES NO NA Recent vaginal discharge?

Physician Signature: _____ **Date:** _____