Documents

	Document Title	Category	Document Date	Document Type	Action Type
1.	medical history form page 4				
2.	medical history form page 3				
3.	medical history form page 2				
4.	medical history form page 1				

35. Persistent pain joints?	☐	☐
36. Back pain?	☐	☐
37. Do you enjoy your work?	☐	☐
38. Frequent conflicts at home?	☐	☐
39. Sexual problems?	☐	☐
40. Do you feel anxious or depressed much of the time?	☐	☐
41. Have you seriously considered suicide?	☐	☐
42. Difficulty in sleeping?	☐	☐
43. History of hospitalization for an emotional problem?	☐	☐
Women Only:		
44. Are menstrual periods normal?	☐	☐
45. Date of last menstrual period?	☐	☐
46. Any vaginal discharge?	☐	☐
47. Any breast discharge?	☐	☐
48. Pregnancies _____ Deliveries _____	☐	☐
49. Bleeding between periods or after menopause?	☐	☐
50. Approximate date of last PAP Smear?	☐	☐
Have you ever had?		
a. Asthma	☐	☐
b. Diabetes	☐	☐
c. Gonorrhea	☐	☐
d. Heart Murmur	☐	☐
e. Heart Attack	☐	☐
f. Hepatitis or Liver Disease	☐	☐
g. Herpes	☐	☐
h. Kidney Stones	☐	☐
i. Phlebitis	☐	☐
j. Pneumonia	☐	☐
k. Polio	☐	☐
l. Rheumatic Fever	☐	☐
m. Stroke	☐	☐
n. Syphilis	☐	☐
o. Thyroid Trouble	☐	☐
p. Tuberculosis	☐	☐
q. Ulcer	☐	☐
r. Other Serious Illnesses Not Mentioned		

Please list below:

_____

_____

_____

_____

_____

_____

_____
Signature of Patient

PERSONAL HABITS:

Tobacco? (type and amount per day)_____ If not smoking now, have you smoked in past _____

Alcohol? (amount per day or week) _____

Have you had a problem with alcohol? ❑ Yes ❑ No

Coffee, Tea and Cola Beverages? (cups per day) _____

Special Diet? _____

Do you have any of the following?	Yes	No	Do Not Write In This Space
1. Recent weight Gain (_____ pounds)	❑	❑	
2. Recent weight Loss (_____ pounds)	❑	❑	
3. Fever or soaking sweats at night	❑	❑	
4. Fatigue	❑	❑	
5. Have you received an injury for which there is now a lawsuit pending?	❑	❑	
6. Is the purpose of this examination to determine the existence or extent of a disability?	❑	❑	
7. Treatment with X-rays?	❑	❑	
8. Weakness or numbness of arms or legs?	❑	❑	
9. Headaches more than once or twice a week?	❑	❑	
10. Difficulty walking?	❑	❑	
11. Loss of consciousness or convulsions?	❑	❑	
12. Problem with vision that is not corrected with glasses?	❑	❑	
13. Change in hearing?	❑	❑	
14. Dizziness?	❑	❑	
15. Frequent or severe nosebleeds?	❑	❑	
16. Trouble chewing or swallowing?	❑	❑	
17. Sore tongue or mouth?	❑	❑	
18. Neck pain or stiffness?	❑	❑	
19. Daily cough?	❑	❑	
20. Short of breath after walking up two flights of stairs?	❑	❑	
21. Short of breath when just sitting or lying down?	❑	❑	
22. Discomfort in the chest?	❑	❑	
23. Swelling of the ankles every day?	❑	❑	
24. Pain in the legs while walking?	❑	❑	
25. High blood pressure?	❑	❑	
26. Abdominal pain?	❑	❑	
27. Frequent heartburn or indigestion?	❑	❑	
28. Change in bowel habits?	❑	❑	
29. Black or bloody bowel movements?	❑	❑	
30. Bloody or otherwise unusual appearing urine?	❑	❑	
31. Difficulty urinating?	❑	❑	
32. Do you lose control of urine at times?	❑	❑	
33. Awaken at night more than once to urinate?	❑	❑	
34. Any skin problems at this time?	❑	❑	

OTHER SERIOUS ILLNESSES:

Year Diagnosis

_____

_____

FAMILY HISTORY: (list parents and all brothers and sisters)

Living? Age State of Health or Cause of Death

Mother _____

Father _____

_____

_____

_____

Is there a family history of any of the following in a blood relative? (please check)

_____ Alcoholism ____Migraine _____Diabetes _____Epilepsy

_____Tuberculosis ____ Glaucoma ____ Stroke ____Nervous Breakdown

_____ Kidney stones or failure _____Heart Attack before 60 ____ High Blood Pressure ____ Breast Cancer

_____Colon Cancer ____Other Cancers____ Others _____

MEDICINES: List all medications that you have been taking recently

(Please include all vitamins as well as prescribed medicine)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES: List all medications and other substances to which you are allergic.

_____

IMMUNIZATIONS:

Pneumonia vaccine _____ (date) _____

Tetanus _____ (date) _____

X RAY STUDIES: Have you had any of the following x-ray studies? List most recent study.

Year Results (if known) Test location

Chest _____

Kidney _____

Stomach _____

Gallbladder _____

Large Bowel _____

Mammogram _____

Others _____

Please COMPLETE and bring this form with you to your appointment

Michigan Urological Clinic

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George G. Carothers, D.O., F.A.C.O.S.
Thomas J. Maatman, D.O. F.A.C.S., F.A.C.O.S.
Kenneth F. Shockley, D.O., F.A.C.O.S.

(please print or type)

Name_____Date_____

Address_____City_____State_____ZIP_____

Phone_____(home) _____(work/cell)

Sex _____ Age _____Date of birth_____Marital status: Single___Married___Widowed___Divorced____Seperated___

Primary Care physician's name _____ Physician's Phone No. _____

Address _____City_____State_____Zip_____

Type of practice (for example, internist, family practice, etc.) _____

Were you referred by your physician? Yes _____ No_____

If not, who referred you to our practice?_____

Shall we send a report to your physician? Yes ____ No____

Occupation _____Working now?_____

If not, last worked _____ Are you disabled for work?_____

Spouse's Occupation _____Number of Children _____Ages_____

What is the chief problem that brings you to the Clinic?_____

_____

How long have you had the problem? _____

What do you think might be causing the problem?_____

PAST MEDICAL HISTORY

Hospitalizations: Year Diagnosis Surgeries (if any)

_____

_____

_____

_____

_____