

Are you experiencing or have you ever experienced any of the following....(Please check all that apply)

- Frequent Headache
- Fever/Chills
- Weight Loss ____ lbs
- Nausea/Vomiting
- Abdominal Pain
- Constipation
- Diarrhea
- Back Pain
- Neck Pain
- Pelvic Pain
- Skin Rashes
- Skin Lesions
- Cataract
- Glaucoma
- Blurred/Double Vision
- Blood in Urine
- Pus in Urine
- Frequent Urination
- Uncontrolled Loss of Urine
- Excessive Thirst
- Feeling of Being Tired
- "Out of Sorts" feeling
- Drug Allergies
- Seasonal Allergies
- Ear Infection
- Difficult Hearing
- Bleeding Gums
- Sore Throat
- Depression
- Anxiety
- Sleep Disorder
- Overly Stressed
- Chest pain
- High Blood Pressure
- Dizzy Spells/Vertigo
- Numbness/Tingling
- Shortness of Breath
- Trouble Breathing
- Swollen Glands
- Easy Bleeding or Bruising
- Swollen Lymph Nodes
- I have not experienced any of the above.

I/My Family has a history of ...(Please check all that apply)

	Me	Family	Explain:
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol/Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/Aids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	_____
OAB/Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach Ulcers/Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Anemia /Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any allergies? Yes No
 If yes, please list _____

Do you take any medication? Yes No
 If yes, please list the medication and dosage:

<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you undergone a surgical procedure? Yes No
 Please list surgeries/hospitalizations, dates, physician performing procedure and name of hospital.

<u>Surgery/Illness</u>	<u>Date</u>	<u>Surgery/Illness</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your Marital Status? Single Married
 Divorced Widow

What is your occupation? _____ Number of Children _____

Do you smoke? Yes No
 If yes, # of packs per day? Less than one Two
 One Three or more

For how long? _____

Do you drink alcohol? Yes No
 If yes, how much? Social Moderate
 Light Excessive

For how long? _____

Do you experience leakage of urine when you sneeze, laugh, cough, etc? Yes No
 Do you experience leakage of urine if you do not get to the bathroom immediately? Yes No
 Do you have pain with urination? Yes No
 Have you seen blood in your urine? Yes No
 Do you experience a feeling of not completely emptying your bladder after urination? Yes No
 Do you go to the bathroom frequently? Yes No
 Do you find it difficult to postpone urination? Yes No
 Do you have to push or strain to begin urination? Yes No
 During urination, do you often experience stopping and starting of urinary stream? Yes No
 Do you find yourself getting up often to urinate during the night? Yes No
 (# of times per night _____)

Patient Signature _____ Date ____/____/____

Reviewed By _____ Date ____/____/____

Physician Signature _____ Date ____/____/____