# John M Cannon, MD

Urology and Urologic Surgery

## PATIENT HISTORY FORM

Name _____ Date of Birth _____ Today's Date _____

Height _____ Weight _____ Referring Doctor _____

**CHIEF COMPLAINTS** – What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

## HISTORY OF PRESENT ILLNESS

**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 problem.**

1 2 3 4 5 6 7 8 9 10

**When did you first notice the problem?**

2 days ago 2 weeks ago 1 month ago

other _____

**Does anything help or make the problem worse?**

Moving around Standing up Lying on my side

Other _____

_____

**How long does the problem last?**

30 minutes 1 hour It is always there

Other _____

**Is anything else occurring at the same time?**

Yes No If yes, please explain.

Nausea Rash Headaches

Other _____

**Is the problem constant or variable?**

Dull then sharp Very sharp then leaves Always there

Other _____

**Does the problem interfere with your normal functions?** Yes No

If yes, please explain _____

_____

**Physician use only:**

## PAST MEDICAL & SOCIAL HISTORY

List all serious illnesses you have had. (Ex: diabetes, tuberculosis, breast cancer, heart disease, etc.)

_____ _____ _____

_____ _____ _____

Medical allergies? _____

Allergic reactions? _____

List past surgeries and when they occurred.

Illness or surgery Date

_____

_____

_____

_____

Are you Diabetic? Y N

Are you on a special diet? Y N (if yes please explain)

_____

Do you smoke tobacco? Y N How much?

Have you ever smoked tobacco? Y N If yes, when?

Do you smoke marijuana? Y N How much?

Do you drink caffeine daily? Y N If yes, how much?

Do you drink alcohol? Y N If yes, how much?

**Physician use only:**

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**REVIEW OF SYSTEMS** Name_____ Date of Birth _____

Do you now or have you had any problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in space provided.

**Constitutional Symptoms**

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |
| Other _____ | | |

**Eyes**

| | | |
|---|---|---|
| Blurred vision | Y | N |
| Double vision | Y | N |
| Pain | Y | N |
| Other _____ | | |

**Neurological**

| | | |
|---|---|---|
| Tremors | Y | N |
| Dizzy spells | Y | N |
| Numbness/tingling | Y | N |
| Other _____ | | |

**Endocrine**

| | | |
|---|---|---|
| Excessive thirst | Y | N |
| Too hot/cold | Y | N |
| Tired/sluggish | Y | N |
| Other _____ | | |

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | Y | N |
| Nausea/vomiting | Y | N |
| Indigestion/heartburn | Y | N |
| Other _____ | | |

**Cardiovascular**

| | | |
|---|---|---|
| Chest pain | Y | N |
| Varicose veins | Y | N |
| High blood pressure | Y | N |
| Other _____ | | |

**Integumentary**

| | | |
|---|---|---|
| Skin Rash | Y | N |
| Boils | Y | N |
| Persistent Itch | Y | N |
| Other _____ | | |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint pain | Y | N |
| Neck pain | Y | N |
| Back pain | Y | N |
| Other _____ | | |

**Ear/Nose/Throat/Mouth**

| | | |
|---|---|---|
| Ear infection | Y | N |
| Sore throat | Y | N |
| Sinus problems | Y | N |
| Other _____ | | |

**Genitourinary**

| | | |
|---|---|---|
| Urine retention | Y | N |
| Painful Urination | Y | N |
| Urinary frequency | Y | N |
| Erection problems (Males) | Y | N |
| Other _____ | | |

**Respiratory**

| | | |
|---|---|---|
| Wheezing | Y | N |
| Frequent cough | Y | N |
| Shortness of breath | Y | N |
| Other _____ | | |

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Swollen glands | Y | N |
| Blood clotting problem | Y | N |
| Other _____ | | |

**Psychological**

| | | |
|---|---|---|
| Are you generally satisfied with your life? | Y | N |
| Do you feel severely depressed? | Y | N |
| Have you considered suicide? | Y | N |
| Other _____ | | |

**Physicians use only:**