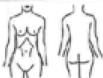
What is the main reason for your visit today? Describe your problem in detail:

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

- WHERE is your problem?
  Abdomen / Back / Genitals / Other)
  Describe: ______



- Do you have any PAIN?
  YES NO (If "NO" skip the next question)

- What KIND of pain do you have? Sharp / Dull / Throbbing / Achy / Pressure / Cramping / Crushing / Vague
  Describe: ______

- On a scale of 1-10, (10 is the most severe) circle the number that best describes the SEVERITY of your problem or your pain.
  (no problem) 1 2 3 4 5 6 7 8 9 10 (most severe)

- When did you FIRST NOTICE the problem? (When did it start?)
  How many (circle one) days / weeks / month(s) ago: ______

- HOW LONG does each episode last?
  Seconds / Minutes / Hours / Days / Always there
  Describe: ______

- WHEN does this problem happen?
  Daytime / Nighttime / When you are active / Unpredictable
  Describe: ______

- HOW OFTEN are you having the problem or the pain?
  Describe: ______

- What HELPS or what makes the problem WORSE?
  Describe: ______

- Are any OTHER SYMPTOMS occurring at the same time?
  Describe: ______

- List all of your current health conditions, and list all hospitalizations and surgeries you have had:

- List all medications you take regularly:

- List all medication allergies:

- Do you smoke? No Yes How Much?

- Do you use drugs or alcohol? No Yes How Much?

- What is/was your occupation? (What did you retire from?)

- What is your current marital status?
  Single / Married / Seperated / Divorced / Widowed

- List all serious illnesses in your family, including parents, grand-parents and siblings. (Diabetes, any kind of cancer, high blood pressure, heart disease, kidney disease or stones, thyroid disease, etc.)
  Mother: ______
  Maternal GM: ______
  Maternal GF: ______
  Father: ______
  Paternal GM: ______
  Paternal GF: ______
  Bro./Sis.: ______

- Do you have any of the following problems TODAY? Please mark YES (Y) or NO (N) for EACH item below.

Y N Kidney disease	Y N Fever	Y N Wheezing	Y N Back pain	Y N Easy bruising
Y N Bloody urine	Y N Chills	Y N Frequent cough	Y N Headaches	Y N Seasonal allergies
Y N Painful urination	Y N Change in Weight	Y N Short of breath	Y N Tremors	Y N Other health problems
Y N Urinary hesitancy	Y N Change in appetite	Y N Abdominal pain	Y N Numbness or tingling	
Y N Urinary retention	Y N Blurred/double vision	Y N Nausea	Y N Dizzy Spells	
Y N Urinary frequency	Y N Eye pain	Y N Vomiting	Y N Anxiety	
Y N Urinary urgency	Y N Ear pain	Y N Indigestion	Y N Depression	
Y N Urinary incontinence	Y N Hearing loss	Y N Heartburn	Y N Insomnia	
Y N Nighttime urinations	Y N Sinus problems	Y N Skin problems	Y N Excessive thirst	
How many? ______	Y N Sore throat	Y N Skin cancer	Y N Intolerant to heat/cold	
DATE last period Started?	Y N Chest pain	Y N Joint pain	Y N Tired or fatigued	
______	Y N Varicose veins	Y N Neck pain	Y N Swollen Glands	

Physician / provider use only (notes/comments):