MEDICAL HISTORY CHECKLIST

Patient Name:

Date:

	DISEASE/CONDITION	Present?	YEAR OF ONSET	TAKING MEDICATION	CHECK IF ON GOING/or add STOP DATE
HEENT	Wears glasses	☐ Yes ☐ No			☐ _____
	Cataracts	☐ Yes ☐ No			☐ _____
	Glaucoma	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
CARDIOVASCULAR	Hypertension	☐ Yes ☐ No			☐ _____
	Hypercholesterolemia	☐ Yes ☐ No			☐ _____
	Congestive Heart Failure	☐ Yes ☐ No			☐ _____
	Coronary Artery Disease	☐ Yes ☐ No			☐ _____
	Venous insufficiency	☐ Yes ☐ No			☐ _____
	Angina	☐ Yes ☐ No			☐ _____
	Arrhythmias	☐ Yes ☐ No			☐ _____
	Myocardial infarction	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
RESPIRATORY	Asthma	☐ Yes ☐ No			☐ _____
	COPD	☐ Yes ☐ No			☐ _____
	Emphysema	☐ Yes ☐ No			☐ _____
	Bronchitis	☐ Yes ☐ No			☐ _____
	Sleep apnea	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
GI	GERD	☐ Yes ☐ No			☐ _____
	Hernia	☐ Yes ☐ No			☐ _____
	Gallbladder disease	☐ Yes ☐ No			☐ _____
	Irritable bowel syndrome	☐ Yes ☐ No			☐ _____
	Pancreatitis	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
HEPATIC	Hepatitis	☐ Yes ☐ No			☐ _____
	Bleeding disorders	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
ENDOCRINE	Diabetes type 1 | 2	☐ Yes ☐ No			☐ _____
	Hypothyroidism	☐ Yes ☐ No			☐ _____
	Hypogonadism	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
MUSULO-SKELETAL	Arthritis	☐ Yes ☐ No			☐ _____
	Back Pain	☐ Yes ☐ No			☐ _____
	Herniated Disc	☐ Yes ☐ No			☐ _____

	DISEASE/CONDITION	Present?	YEAR OF ONSET	TAKING MEDICATION	CHECK IF ON GOING/or add STOP DATE
CNS/NEURO-LOGICAL	Cerebral Vascular Accident	☐ Yes ☐ No			☐ _____
	Seizures	☐ Yes ☐ No			☐ _____
	Parkinson's disease	☐ Yes ☐ No			☐ _____
	Migraine/headaches	☐ Yes ☐ No			☐ _____
	Insomnia	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
PSYHIATRIC	Depression	☐ Yes ☐ No			☐ _____
	Anxiety	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
ALLEGIES	Drug	☐ Yes ☐ No			☐ _____
	Seasonal	☐ Yes ☐ No			☐ _____
UROLOICAL	BPH	☐ Yes ☐ No			☐ _____
	Incontinence Urge or stress	☐ Yes ☐ No			☐ _____
	Nocturia	☐ Yes ☐ No			☐ _____
	OAB	☐ Yes ☐ No			☐ _____
	Erectile Dysfunction	☐ Yes ☐ No			☐ _____
	Kidney Stones	☐ Yes ☐ No			☐ _____
	Bladder Cancer	☐ Yes ☐ No			☐ _____
	Prostate Cancer	☐ Yes ☐ No			☐ _____
	Peyronies	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____
OTHER	ALCOHOL ABUSE	☐ Yes ☐ No			☐ _____
	SUBSTANCE ABUSE	☐ Yes ☐ No			☐ _____
	Other:	☐ Yes ☐ No			☐ _____

Medical History Obtained by: _____