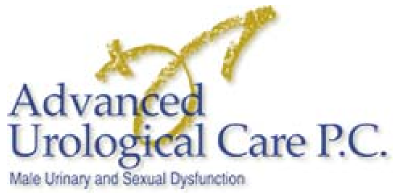

Patient History Form
J. Francois Eid, M.D.

Note: Confidential

Date: ________________

Name: ______________________________

Address: ____________________________

____

Age: _________ Date of Birth: __________

We would like to send a letter to update your referring physician. Yes No

Referring Physician: ____________________

Telephone Number: _____________________

Primary Care Physician: _________________

Telephone Number: _____________________

Note: If the telephone number is not provided, no letter will be sent out.

Chief Complaint:

What is the main reason for your office visit today (please describe in detail)?

____

____

Past Medical and Social History

1. Do you have any medical illnesses or conditions? Yes No

Circle any of the following that apply:
1. High blood pressure
2. High cholesterol levels
3. Heart disease
4. Diabetes

____

____

____

2. List all <u>serious</u> illnesses in your immediate family.

____

____

3. List any personal treatments and surgeries (operations) and when they occurred.

Surgery ____ Date __________________

Surgery ____ Date __________________

Surgery ____ Date __________________

Radiation Therapy __________________________________ Date __________________

Chemotherapy ______________________________________ Date __________________

4. Drug Allergies: Yes No

Please list: ____

5. Medications: Yes No

Please list all drugs, medications, eye drops, etc.

____

____

Do you take any medications that fall into the category of nitrates? Yes No
Do you carry nitroglycerin with you in case of emergencies? Yes No
Do you use a skin patch for the delivery of medications? Yes No

6. Alcohol Intake:

Do you drink alcohol (beer, wine, liquor, etc.)? Yes No

If yes: Type ______________________________ Amount ______________________

7. Tobacco Use:

Do you or did you ever smoke? Yes No
If yes: How many pack(s) per day? ____________

For how many years? _________________

If you stopped, how long ago? ___________

8. Psychological History:

Have you ever consulted a psychiatrist, psychologist, or other psychotherapist? Yes No

If yes, please describe the reason: ____

____

____

Were you diagnosed with any of the following:

Depression?	Yes	No
Obsessive-compulsive disorder?	Yes	No
Bipolar disorder?	Yes	No
Psychosis/Neurosis?	Yes	No

Physician's Notes:

BENIGN PROSTATE ENLARGEMENT

____ Date of Visit _____________

Urinary Symptoms	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. Over the past month, how often have you had the sensation that your bladder was not completely empty after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate again less than two hours after you last finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times while urinating?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urinating?	0	1	2	3	4	5

7. Over the last month, how many times did you typically get up to urinate each night, from the time you until the time you got up in the morning?

None 1 time 2 times 3 times 4 times 5 or more times

TOTAL AUA Symptom Score = Sum of questions 1 -7 ______________

Review of Symptoms

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

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Headaches	Yes	No
Weight loss	Yes	No
Other _______________	Yes	No

Eyes

Blurred vision	Yes	No
Double vision	Yes	No
Pain	Yes	No
Other _______________	Yes	No

Neurological

Tremors	Yes	No
Dizzy spells	Yes	No
Numbness	Yes	No
Other _______________	Yes	No

Integumentary

Skin rash	Yes	No
Boils	Yes	No
No		
Persistent itch	Yes	No
Other _______________	Yes	No

Musculoskeletal

Joint pain	Yes	No
Neck pain	Yes	No
Back pain	Yes	No
Other _______________	Yes	No

Ear/ Nose/ Throat/ Mouth

Ear infection	Yes	No
Sore throat	Yes	No
Sinus problems	Yes	No
Other _______________	Yes	No

Genitourinary

Urine retention	Yes	No
Painful urination	Yes	No
Urinary frequency	Yes	No
Other _______________	Yes	No

Endocrine

Excessive thirst	Yes	No
Too hot/cold	Yes	No
Tired/sluggish	Yes	No
Other _______________	Yes	No

Gastrointestinal

Abdominal pain	Yes	No
Nausea/ vomiting	Yes	No
Indigestion	Yes	No
Other _______________	Yes	No

Cardiovascular

Chest pain	Yes	No
Varicose veins	Yes	No
High blood pressure	Yes	No
Other _______________	Yes	No

Respiratory

Wheezing	Yes	No
Frequent coughs		Yes
Shortness of breath	Yes	No
Other _______________	Yes	No

Hematological / Lymphatic

Swollen glands	Yes	No
Blood clot problems	Yes	No
Other _______________	Yes	No

Allergic / Immunologic

Hay fever	Yes	No
Drug allergies	Yes	No
Other _______________	Yes	No

Psychological

Are you generally satisfied with your life? Yes No

Do you feel seriously depressed? Yes No

Have you considered suicide? Yes No

Other _________________________________

New Patient Questionnaire

Name: ______________________________

Date: ______________________

Thank you in advance for filling out this quick survey.

How were you referred to Dr. Eid?

______ Another Doctor
If so, who referred you? ____

______ Newspaper Advertisement
If so, which newspaper?
_____ Daily News
_____ NY Resident
_____ Other

______ Newspaper Article
If so, which newspaper?
_____ Daily News
_____ Other: ___________________________

______ Internet
If so, which web site?
_____ Advanced Urological Care Web site
_____ Search Engine
_____ Healthology (ABC News)
_____ Other: ___________________________

______ Other Publication
If so, which one?
_____ New York Magazine "Best Doctors" Issue
_____ Connelly's Guide
_____ Other: ___________________________

______ Friend

______ Self-Referral

______ Other: ____