

Chief Complaint (purpose of today's visit): _____

Since your last visit, have you had any NEW problems with...

Your heart/heart attack, blood pressure, or angina?	_____yes	_____no
Your stomach/ulcers or colon?	_____yes	_____no
Pains or difficulty with you arms or legs?	_____yes	_____no
Headache, dizzy spells or fainting, or stroke?	_____yes	_____no
Diabetes or control of your blood sugar?	_____yes	_____no
Lungs/breathing or asthma/COPD?	_____yes	_____no
Bleeding disorders or easy bruising?	_____yes	_____no
Glaucoma or cataract issues/surgery?	_____yes	_____no

PLEASE PROVIDE AN UPDATED LIST OF YOUR MEDICATIONS OR LIST BELOW.

PLEASE PROVIDE AN UPDATED LIST OF ANY FOOD OR MEDICATION ALLERGIES.

Any surgeries or procedures since your last visit?	_____yes	_____no
If yes, _____		
Any changes in drinking or smoking habits?	_____yes	_____no
If yes, _____		

SINCE YOUR LAST VISIT, HAVE YOU NOTICED...

Any changes in your ability to urinate?	_____yes	_____no
Any burning while urinating?	_____yes	_____no
Any blood in your urine?	_____yes	_____no
Any difficulty starting or stopping your stream?	_____yes	_____no
Any severe urgency to urinate?	_____yes	_____no
Any difficulty with sexual activity?	_____yes	_____no
Any difficulty with control of your urine/incontinence?	_____yes	_____no

THANK YOU FOR UPDATING YOUR MEDICAL RECORD. PLEASE SIGN BELOW.

NAME/SIGNATURE: _____ Date: _____