PREMIER medical group

PREMIERMEDICALHV.COM

Phone: (845)437-5000 Fax: (845)452-4314

_____ _____

PATIENT NAME *DATE OF BIRTH*

What is the reason for your visit to Premier Medical Group? _____

_____

What are your current symptoms? _____

_____

Were you referred by another physician? ☐ **YES** ☐ **NO**

If yes, who referred you? _____

Phone: _____ **Fax:** _____

Have you had any recent testing? (Blood work / CT Scan / X-Ray / Ultrasound)

☐ **YES** ☐ **NO** **If yes, where did you have that testing and when?** _____

_____

MEDICATION

NAME OF MEDICATION	DOSAGE	TAKEN HOW OFTEN

Do you have any allergies to Latex, Iodine, IV Contrast or Dyes ☐ **YES** ☐ **NO**

Do you have any allergies to medications? ☐ **YES** ☐ **NO** **If yes, please list the Medications. If additional space is needed, use the back of this document or attach a list**

_____

_____

_____

_____

GENERAL MEDICAL HISTORY

Have you ever been diagnosed with any medical problems? _____

_____

_____

_____

Have you ever had any surgical procedures? (If yes, please list the year surgery occurred and include childhood surgeries, if any.)

_____

_____

_____

_____

Any immediate (parents, grandparent, siblings) family history of Bladder Cancer, Kidney Cancer, Prostate Cancer or Kidney Stones? ☐ **YES** ☐ **NO**

If yes, please indicate which diagnosis and what family member had the problem

_____

_____

Are your parents living? ☐ **YES** ☐ **NO** **If yes, do they have any major medical issues?:** ____

_____

_____

If your parents are deceased, please indicate the cause of death and their age at the time of death?

_____

_____

Do you consume alcohol? ☐ **YES** ☐ **NO** **If yes, how often?** _____ **How much?** _____

Do you currently use any illegal drugs? ☐ **YES** ☐ **NO**

If yes, what type of drugs do you use and when did you last use? _____

_____

_____

Did you use any illegal drugs in the past? ☐ **YES** ☐ **NO** **If yes, how many years did you use?** ___

If yes, what type of drugs did you use and when did you last take it? _____

_____

Do you use any tobacco product? ☐ **YES** ☐ **NO** **If yes, for how many years?** _____

What tobacco product do you use? (Check all that apply)

☐ **Cigarettes** ☐ **Pipes** ☐ **Cigars** ☐ **Chewing Tobacco**

How often do you use tobacco products? _____

If you do or did smoke, how many packs per day? _____

If you are a former smoker, when did you quit? _____

Do you have a history of sexually transmitted diseases? ☐ **YES** ☐ **NO**

If yes, what STD did or do you have? _____

When were you diagnosed? _____

GENERAL INFORMATION

Do you have an Advance Directive / Health Care Proxy? ☐ **YES** ☐ **NO**

<u>If yes, please bring a copy to your appointment</u> so we may have it as part of your medical chart.

Current Marital Status: ☐ **Married** ☐ **Single** ☐ **Widow/Widower** ☐ **Separated** ☐ **Divorced**

Do you have any children? ☐ **YES** ☐ **NO** **If yes, how many children?** _____

When was your last Mammogram? _____ **Pap smear?** _____

Currently employed? ☐ **YES** ☐ **NO** **Retired?** ☐ **YES** ☐ **NO**

If yes, what is or was your occupation? _____

Have you now or ever been exposed to any environmental hazards? (Chemicals, Toxins, Smoke, etc.)

☐ **YES** ☐ **NO** **If yes, what are you or were you exposed to?** _____

Do you take any hair growth medications (oral or topical)? ☐ **YES** ☐ **NO**

If yes, what is the name of the medication? _____

Do you take any supplements for prostate health either prescribed by another physician or on your own? ☐ **YES** ☐ **NO** **If yes, what is the name of the supplement?** _____

Thank you for completing this form