Chart #________________

Dallas Center for Pelvic Medicine Patient History Form

Patient Name____ **Date**:_________________

Reason for your visit today____

Name of referring physician ____**Physician phone number**_________________

Drug allergies:____ **ALLERGY TO:** ___Latex? ___IV Contrast? ___Iodine?

Have you been out of the country in the last 3-months? ☐ YES ☐ NO Where?____

RACE: White ___ Black ___ Asian ___ Hispanic ___ Other ______ **Occupation**____________________________________

Do you take antibiotics before going to the dentist office? Y / N If so, for what condition? ______________________________

What do you usually take prior to dental procedures? _____________________________ **Height** __________ **Weight** ___________

Past Medical History:					
Cancer	Y / N	Hepatitis (Type: A / B / C)	Y / N	Thyroid disorder	Y / N
Diabetes	Y / N	Hypertension (high BP)	Y / N	Other:	
Fibromyalgia	Y / N	Irritable bowel syndrome	Y / N		
Heart disease	Y / N	Kidney stones	Y / N		

List all the surgeries you have had in the past

Surgery:	**Year**	**Surgery:**	**Year**

Social History:		
Alcohol	Y / N	____ drinks per day / week / month
Street drugs/drug abuse	Y / N	Type of drugs:
Smoking/Tobacco	Y / N	____ packs per day; ______# years
Did you quit smoking?	Y / N	
Regular exercise	Y / N	____ # minutes ; ____ # times per week
Caffeine use	Y / N	____ # servings per day
Last menstrual period / /		Birth control method
Onset of menopause / /		Hormone replacement use: Currently Previously Never
Marital status: (circle) single married widow/widower		
# pregnancies ______ # births ______ # miscarriages _____ # abortions ______		

Family History:		**Family member affected**
Cancer: list type and location	Y / N	
Any family member on dialysis	Y / N	
Heart disease	Y / N	
Hypertension	Y / N	
Kidney stone disease	Y / N	
Renal cysts or tumors	Y / N	
Renal failure	Y / N	
Sickle cell disease or trait	Y / N	

Dallas Center for Pelvic Medicine

Review of Systems

Patient Name:________________________________ Date:______________

Check any problems you are having?

Abdominal pain		Indigestion / heartburn	
Back pain		Joint pain	
Blood clotting problems		Joint swelling	
Blood in urine		Leakage of urine	
Blurred vision		Nausea / vomiting	
Burning with urination		Neck pain	
Chest pain		Numbness / tingling	
Chills		Painful urination	
Cold intolerance		Palpitations	
Constipation		Persistent itch	
Cough		Rash	
Depression		Shortness of breath	
Diarrhea		Sinus problems	
Difficulty emptying bladder		Slow urine stream	
Dizziness		Sore throat	
Double vision		Swollen lymph nodes	
Elevated BP		Tired / sluggish	
Extreme thirst		Tremors	
Fecal incontinence		Urinary frequency	
Fecal urgency		Urinary hesitancy	
Fever		Urinary urgency	
Hay fever symptoms		Urinating frequently at night	
Headache		Varicosities (varicose veins)	
Heat intolerance		Weakness	
Inability to empty bladder		Wheezing	

MEDICATION	DOSE	TIMES PER DAY