

**Mount Sinai School of Medicine
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PATIENT HISTORY FORM

Date _____

Name _____

Date of Birth _____ Age _____

HISTORY ON PRESENT ILLNESS

What is the main reason for your visit? (Describe in detail)

When did you first notice the problem?

Have you seen any doctors for this problem? If so, who have you seen?

PAST MEDICAL HISTORY

Please list any medical problems you have had, and any hospitalizations:

Illness/Hospitalization	Date
_____	_____
_____	_____
_____	_____

Please list any surgical procedures you have had:

Surgical Procedures	Date
_____	_____
_____	_____
_____	_____

MEDICATIONS

Please list all medications you are currently taking: (including: Aspirin, Vitamins, Supplements, etc)

ALLERGIES

Do you have any allergies to medications? If so, please list below:

NAME: _____

SOCIAL HISTORY

Do you smoke? ___ Yes ___ No If yes, how much? _____

Do you drink alcohol? ___ Yes ___ No If yes, how much? _____

Do you drink any of the following containing caffeine? If so, how many cups?

Coffee _____ Tea _____ Soda _____

Do you use any drugs? ___ Yes ___ No If yes, which one(s) _____

* weight _____
Height _____

Are you employed? If so, what do you do? _____

Are you: (Check one) ___ Married ___ Single ___ Widowed ___ Divorced

How many children do you have? _____ What ages are they? _____

FAMILY HISTORY

Do you have any family history of the following?

___ Kidney Stones ___ Prostate Cancer ___ Testicular Cancer
___ Kidney Cancer ___ Bladder Cancer ___ Diabetes Other _____

REVIEW OF SYSTEMS

Do you now or have you had any of the following? (Circle Yes or No)

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Persistent Itch	Y	N
Headaches	Y	N
Weight Loss	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Lower Back Pain	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Glaucoma	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N
Stuffiness	Y	N
Change in voice	Y	N
Decreased hearing	Y	N
Hoarseness	Y	N
Fatigue	Y	N
Loose/Capped teeth	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Other _____		

NAME: _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness	Y	N
Tingling	Y	N
Seizures	Y	N
Weakness	Y	N

Integumentary

Skin Rash	Y	N
Persistent itch	Y	N
Skin Cancer	Y	N
Other _____		

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Difficult Urination	Y	N
Urinary Frequency	Y	N
Kidney Failure	Y	N
Kidney Stones	Y	N
Sexual Dysfunction	Y	N
Other _____		

Respiratory

Shortness of Breath	Y	N
Asthma	Y	N
Bronchitis	Y	N
Wheezing	Y	N
Frequent coughs	Y	N
Tuberculosis	Y	N
Pain with breathing	Y	N

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Thyroid Disease	Y	N
Diabetes	Y	N
Other _____		

Hematological/Lymphatic

Swollen glands	Y	N
Blood clotting	Y	N
Low blood counts	Y	N
Blood transfusions	Y	N
Bleeding	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Ulcer	Y	N
Food intolerance	Y	N
Jaundice	Y	N
Hepatitis	Y	N
Other _____		

Psychologic

Are you satisfied with your life?	Y	N
Have you considered suicide?	Y	N
Do you hear voices?	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Mitral valve prolapse	Y	N
Varicose veins	Y	N
Palpitations	Y	N
Irregular Heart Beat	Y	N
Heart attack	Y	N
Abnormal ECG	Y	N

Physician use only: (Comments/Notes)

All other ROS Negative

Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____