**Douglas L. Gaker, M.D., Inc.**
**Personal Health History**

Patient Name:___________________________________ DOB:_________________ Date:_______________
Signature:_____________________________________________________________________________
Are you allergic to any medications? ___YES ___NO If yes, list____________________________________
What type of reaction do you have?______________________________________________________

List all medications you are currently taking (including prescriptions, over the counter meds, vitamins, and herbals):
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Do you have now, or have you ever had diseases or conditions of: (Please check yes/no)

| **Lungs:** | **Yes** | **No** | **Other Systemic:** | **Yes** | **No** |
|---|---|---|---|---|---|
| Bronchitis | ___ | ___ | Diabetes | ___ | ___ |
| Emphysema | ___ | ___ | Thyroid | ___ | ___ |
| Asthma | ___ | ___ | Kidney | ___ | ___ |
| Shortness of Breath | ___ | ___ | Bladder Incontinence | ___ | ___ |
| Wheezing | ___ | ___ | Frequency/burning | ___ | ___ |
| | | | Gastrointestinal | ___ | ___ |
| **Cardiovascular:** | **Yes** | **No** | Nausea, vomiting, diarrhea | ___ | ___ |
| High Blood Pressure | ___ | ___ | Yeast infection when | | |
| Heart Attack | ___ | ___ | taking antibiotics | ___ | ___ |
| Heart Murmur | ___ | ___ | Arthritis/Joint Deformity | ___ | ___ |
| Irregular Heartbeat | ___ | ___ | | | |
| Blood Clots | ___ | ___ | **Artificial Joint** | ___ | ___ |
| **Pacemaker** | ___ | ___ | Convulsions, Epilepsy | ___ | ___ |
| **Heart valve** | ___ | ___ | Seizures | ___ | ___ |
| | | | Fainting | ___ | ___ |

List any other diseases or conditions:___________________________________________________
List surgical procedures you have had:___________________________________________________

**History:**
Is there any family history of prostate disease?___________________________________________
Is there any family history of bladder cancer?_____________________________________________
Is there any family history of kidney stones?______________________________________________
Have you had a recent unusual change in weight?__________________________________________
Have you had unusual appetite changes recently?__________________________________________
Have you had any obvious changes in a wart or mole?______________________________________
Can you walk a mile?_________________________________________________________________
Do you have problems with memory or mood changes?_____________________________________
Do you have problems with severe back or leg pain?_______________________________________

Do you have difficulty swallowing?____________________________________________________________

Do you have a sore that doesn't heal?____________________________________________________________

Do you have bleeding problems that seem unusual?_________________________________________________

**Social History:**

Do you drink alcohol? ___ YES ___NO If YES, _______ drinks per day

Do you smoke? ___YES ___NO If YES, how much: ________________