

Robert J. Cornell, MD, PA
Patient Medical History Form

Patient Name: _____ Date: _____

Sex: Male ___ Female ___ Age: _____ Marital Status _____

How did you hear about Dr.Cornell? _____

Primary Care Physician: _____ **Occupation:** _____

Work Status: Presently working _____ Retired ___ Disabled _____

Reason for visit today: _____

Height _____ Weight _____

Do You: Smoke No ___ Yes ___ if yes How Long? _____ Number of Packs per day? _____

Do You: Drink Alcohol? No ___ Yes ___ if yes how much? _____

Ongoing medical illnesses (include diagnosis): _____

Prior Surgery including Month/Year: _____

Other Hospitalizations including Month/Year: _____

List **current Medicines** you are taking (including dosage): _____

List **Allergies** to Medicines: _____

Family History/Diseases:

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Patient Name: _____ Date: _____

****Males Only****

Erectile Dysfunction No _____ Yes _____

Urinary Leakage No _____ Yes _____

Number of times awakened to urinate at night: _____

****Females Only****

Urinary Leakage: No _____ Yes _____ Urinary Frequency: No _____ Yes _____

Are you pregnant? No _____ Yes _____ # of pregnancies: _____ # of children: _____

Please check if you have now or have had in the past any of the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Anesthesia Issues | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Leg/Foot Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Disorder | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Nerve Disorder | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood In Urine | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Vein Clot |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disorders | <input type="checkbox"/> Poor Circulation | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Sickle Cell | |

Other Conditions: _____

This information is correct to the best of my knowledge.

Patient's Signature

Date