



Patient Questionnaire
(Updated Yearly)

Name _____ Date of Birth _____ Date _____

Name and address of primary care doctor: _____

Other doctors you currently see (Include name and specialty):

1. _____ 2. _____
3. _____ 4. _____

Past Medical History

A. List all medical conditions (e.g. heart disease, Heart attack, diabetes, high blood pressure, Stroke, emphysema, etc):

1. _____
2. _____
3. _____
4. _____

B. List all medications including aspirin, herbal supplements & vitamins. (continue on back if necessary):

1. _____
2. _____
3. _____
4. _____

C. List any surgeries you have had (and dates):

1. _____
2. _____
3. _____

D. List any allergies to medications:

1. _____
2. _____
3. _____

E. Do you currently smoke? Yes / No If yes, state how many packs per day and number of years. If you previously smoked and have quit, please also state year when you last smoked.

F. Do you use alcohol? Yes / no If yes, state roughly how often. _____
Have you ever had a problem with excessive alcohol use? yes / no

Family History

Do you have a family history of (circle all that apply): kidney stones, prostate cancer, bleeding problems, Kidney tumors, problems with anesthesia during surgery, diabetes, high blood pressure, heart problems, other: _____

Social History

Marital Status: _____ Number of children: _____
Working / Retired _____ Type of Work _____

Past Urologic History

Have you ever had: (circle yes or no)

- | | | | |
|----------------------------|----------|----------------------------------|----------|
| 1. trouble passing urine | yes / no | 9. Prostate Surgery | yes / no |
| 2. urinary tract infection | yes / no | 10. prostate cancer | yes / no |
| 3. blood in urine | yes / no | 11. bladder or kidney surgery | yes / no |
| 4. kidney stones | yes / no | 12. sexually transmitted disease | yes / no |
| 5. cystoscopy | yes / no | 13. kidney problems or failure | yes / no |
| 6. bladder tumor | yes / no | 14. urinary incontinence | yes / no |
| 7. prostate enlargement | yes / no | (involuntary loss of urine) | |
| 8. impotence (men only) | yes / no | | |

Gynecologic History (women only)

Date of last menstrual period: _____ Could you be pregnant? Yes / no
Number of pregnancies _____ # of children: _____ # vaginal deliveries _____ # C-sections _____
History o (circle all that apply): endometriosis, cancer of cervix, uterus, or ovaries, pelvic radiation, hysterectomy, menopause, prolapse bulge in vagina.

Name _____ Date of Birth _____ Date _____



Review of Systems

Do you currently have any problems related to the following systems? Circle **Yes** or **No**

Please explain any Yes answers in the space provided.

Constitutional Symptoms				Skin			
Fever	Yes	No		Skin Rash	Yes	No	
Chills	Yes	No		Boils	Yes	No	
Headache	Yes	No		Persistent Itch	Yes	No	
Other				Other			
Eyes				Musculoskeletal			
Blurred Vision	Yes	No		Joint Pain	Yes	No	
Double Vision	Yes	No		Neck Pain	Yes	No	
Pain	Yes	No		Back Pain	Yes	No	
Other				Other			
Allergic/Immunologic				Ears/Nose/Throat/Mouth			
Hay Fever	Yes	No		Ear Infection	Yes	No	
Drug Allergies	Yes	No		Sore Throat	Yes	No	
Other				Sinus Problems	Yes	No	
Neurological				Other			
Tremors	Yes	No		Respiratory			
Dizzy Spells	Yes	No		Wheezing	Yes	No	
Numbness/Tingling	Yes	No		Frequent cough	Yes	No	
Other				Shortness of breath	Yes	No	
Endocrine				Other			
Excessive	Yes	No		Hematologic/Lymphatic			
Too Hot/Cold	Yes	No		Swollen glands	Yes	No	
Tired/Sluggish	Yes	No		Blood clotting problem	Yes	No	
Other				Other			
Gastrointestinal				Psychologic			
Abdominal pain	Yes	No		Are you generally satisfied with your life?	Yes	No	
Nausea/Vomiting	Yes	No		Do you feel severely depressed?	Yes	No	
Indigestion/heartburn	Yes	No		Have you considered suicide?	Yes	NO	
Other				Other			
Cardiovascular							
Chest pain	Yes	No					
Varicose Veins	Yes	No					
High Blood Pressure	Yes	No					
Other							

(Comments/Notes)

	#Answer	Level of Service
	0-1	1 or 2
	2-9	3
	10+	4or5

Physician: _____	Date	/ / _____
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