

Patient Questionnaire for Urology

Your Name: _____ Your Age: _____ Today's Date: _____

Dear Patient: A few minutes of your time carefully answering the following questions will help the physicians more accurately assess your problem and give you better care. Thank you!

- What is the name of the doctor who sent you for evaluation? _____
- What is the **main reason** you are seeing the doctor today? _____
- Have you ever seen a urologist before? YES _____ NO _____

I. HISTORY OF PRESENT ILLNESS:

1. For what length of time have you had this problem? _____
2. Where is the problem located? _____
3. What signs or symptoms are you having? _____
4. Does anything make the problem better or worse? _____
Are you currently taking any medications to treat the symptoms? _____
5. Does the problem interfere with normal daily function? _____
If YES, explain: _____
6. How long does the problem last? CIRCLE: Seconds; Minutes; Hours; Days; All the time
7. On a scale of 1-10, with 10 being the most severe, circle the number that best describes your problem:

1 2 3 4 5 6 7 8 9 10

II. UROLOGIC HISTORY: Have you ever had cancer? YES _____ NO _____

Have you ever had the following? **CIRCLE if YES.**

Painful urination	Urinate too often	Slow urination	Urinary incontinence
Urinary infection	Bladder trouble	Kidney disease	Nephritis
Dialysis	Kidney failure	Blood in the urine	Urinary problem as a child
Kidney stones	Had to wear a catheter	Injury to the urinary tract	Urinary surgery
MEN:	Prostate gland trouble	Abnormal PSA	Prostate biopsy
WOMEN:	Abnormal periods	Female hormone problem	Problem with uterus /ovaries

Could you be pregnant now? YES _____ NO _____; Are you on birth control now? YES _____ NO _____
Type of birth control: Pill _____ Other _____; Number of Pregnancies? _____; Number of Births? _____

III. PAST MEDICAL HISTORY:

1. Are you allergic to any medication? YES _____ NO _____
If you are allergic to any medications, please list them:
(1) _____ (2) _____ (3) _____
(4) _____ (5) _____ (6) _____
2. List the NAMES (and DOSE if known) of the prescription medicine you take every day:
(1) _____ (2) _____
(3) _____ (4) _____
(5) _____ (6) _____
(7) _____ (8) _____
3. Do you take ASPIRIN? YES _____ NO _____; COUMADIN? YES _____ NO _____; PLAVIX? YES _____ NO _____
Do you take any non-prescription medications, nutritional supplements, vitamins or health food store Medications? YES _____ NO _____
If YES, please list: _____

PLEASE ANSWER THE QUESTIONS ON THE BACK OF THIS FORM.

4. List all the operations or surgery you have ever had and the date of surgery

- (1) _____ (2) _____
- (3) _____ (4) _____
- (5) _____ (6) _____

5. Have you ever had a blood transfusion? YES ___ NO ___

6. Have you ever had any of the following? CIRCLE if YES

- | | | | |
|---------------------|-------------------|--------------------------|-------------------|
| Heart attack | Heart failure | Heart trouble | Pacemaker |
| High blood pressure | Stroke | Glaucoma | Sugar diabetes |
| Stomach ulcers | Tuberculosis | Seizures | Radiation therapy |
| Cancer | Trouble breathing | Problems with anesthesia | False teeth |

7. Have you ever had any other serious medical problems? YES ___ NO ___

If YES, please list:

IV. FAMILY/SOCIAL HISTORY:

1. Have any of the men in your family ever had prostate cancer? YES ___ NO ___
IF YES, Circle: Father, Grandfather, Brother, Uncle, Cousin
2. Any other history of kidney or urinary tract disease in your family? YES ___ NO ___
3. Any other serious diseases in your family such as TB ___ Diabetes ___ Cancer ___
Other: _____
4. Are you on a special diet? YES ___ NO ___; If yes, what type? _____
5. Do you use tobacco? YES ___ NO ___; Circle: Cigarettes, Cigars, Pipe, Chew; No/day _____
6. Do you drink alcohol? YES ___ NO ___; What type? _____ How much? _____
7. Are you: Single ____, Married ____, Divorced ____, Widowed ____
8. What is your occupation? _____

V. REVIEW OF SYSTEMS:

- Do you have any of the following problems at this time? CIRCLE if YES or NONE
- Write in any additional problems you have that are not listed below.

Const. Symptoms:	Fever	Chills	Headaches	Weight Loss	None
Eyes:	Eye Pain	Blurred Vision	Double Vision	Loss of Night Vision	None
Neurological:	Dizzy	Passing Out	Numbness	Seizures	None
Endocrine:	Too Hot	Too Cold	Excessive Thirst	Tired/Sluggish	None
Gastrointestinal:	Nausea	Indigestion	Vomiting	Abdominal Pain	None
	Diarrhea	Constipation	Blood in stool	Stomach Ulcers	
Cardiovascular:	Chest Pain	Leg Cramps	Irregular Heartbeat	Palpitations	None
	Angina	Swollen Ankles	Varicose Veins		
Respiratory:	Wheezing	Frequent Cough	Coughing Up Blood	Shortness of Breath	None
	Excessive Snoring		Must Sleep Sitting Up		
Skin:	Rash	Boils	Dry Skin	Moles/Abn Freckles	None
Musculoskeletal:	Joint Pain	Neck Pain	Back Pain	Arthritis	None
Blood/Lymphatic:	Anemia	Bleed Easily	Bruise Easily	Swollen Glands	None
Allergy/Immun:	Asthma	Hay Fever	Food Allergy	Other Allergies	None
Ear/Nose/Throat	Sinus	Sore Throat	Hoarse Voice	Hearing Loss	None
Psychologic/Mental:	Nervous	Depression	Forgetful		None

PHYSICIAN SIGNATURE: _____ **M.D. DATE:** _____