

Urological Associates, P.C. Health History Questionnaire:

Name _____ Date _____ Age _____ Chart No. _____

What is the primary reason you have a new appointment with this urologist?

For what illnesses are you followed regularly by other physicians?

Are you currently anemic? _____ Do you have any bleeding disorders? _____ Diabetes? _____ How long _____

What Medications are you allergic to?

What Medications do you take regularly, and what is the dosage?

Medication:	Dose:	Medication:	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any blood thinners or daily aspirin? _____

Do you take insulin? _____ Do you take Glucophage? _____

What previous operations or surgery have you had?

Have you had any joint replacements, such as a hip or knee? _____ Back surgery _____

Have you had any of your heart valves replaced? _____

Females:

Date of last menstrual cycle: _____

Number of pregnancies: _____

Number of children: _____

Continued on the back.

In the last year or so, have you experienced any of the following symptoms or diagnoses which have not been evaluated and/or treated? Please mark or circle the appropriate answer:

Fevers which you could not explain? -----Yes No
Weight loss which you could not explain?--Yes No
Chronic rashes or skin problems-----Yes No
Does your hair “fall out in clumps”?-----Yes No
Loss of hearing?-----Yes No
Chronic hoarseness or inability to speak?----Yes No
Chest Pain-----Yes No
Fluttering or quivering around your heart or Chest?-----Yes No
Heart Attack?-----Yes No
Heart valve problems?-----Yes No
Does your dentist give you antibiotics for a Heart valve problem prior to dental work?--Yes No
Have you ever had “Rheumatic Fever”?-----Yes No
Chronic cough?-----Yes No
Excess sputum or phlegm production?-----Yes No
Do you have “Emphysema” or “COPD”?----Yes No
Do you become short of breath from light Exertion?-----Yes No
From walking up 1 flight of steps?-----Yes No
From walking less than one block on a level surface?-----Yes No
Do you get short of breath at rest?-----Yes No
Have you had ulcers?-----Yes No
Have you had “GI Bleeding”?-----Yes No
Vomited blood?-----Yes No
Noticed blood in your stool?-----Yes No
Frequent constipation?-----Yes No
Frequent diarrhea?-----Yes No
Do you have any thyroid diseases?-----Yes No
Do you feel you tire too easily?-----Yes No
Do you have “hot flashes”?-----Yes No

Do you have severe arthritis?-----Yes No
Other bone or joint problems?-----Yes No
Do you have severe osteoporosis?-----Yes No
Have you had seizures?-----Yes No
Epilepsy?-----Yes No
Severe prolonged headaches?-----Yes No
Migraine headaches?-----Yes No
Have you had strokes or “CVA’s”?-----Yes No
Do you have tremors?-----Yes No
Weakness of the legs?-----Yes No
Numbness of the feet or legs?-----Yes No
Do you have Parkinson’s Disease?-----Yes No
Multiple Sclerosis?-----Yes No
Alzheimer’s Disease?-----Yes No
Have you developed unexplained visual Difficulties?-----Yes No
Double vision-----Yes No
Do you have Glaucoma-----Yes No
Do you have trouble remembering?-----Yes No
Do you suffer from psychosis or chemical Imbalance in the brain?-----Yes No
“Manic Depression” or “Bi-polar Disorder”?Yes No
Depression?-----Yes No
Are you losing sleep because you worry?----Yes No
Overly anxious, nervous, or stressed?-----Yes No
Are you afraid you have a terrible disease which doctors have been unable to find? Yes No
Do you have “Rheumatoid Arthritis”?-----Yes No
Do you have “Lupus”?-----Yes No
Are you allergic to a lot of things?-----Yes No
Do you have any swollen lymph nodes or bumps which will not go away?-----Yes No