Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)* ☐ M ☐ F **DOB:** _____/_____/_____

PRESENT UROLOGIC HEALTH CONCERN(S)

Please describe your current urologic problem(s) and why you are seeking consultation.

ILLNESSES (Check all that apply)

Have you ever been diagnosed with any of the following illnesses or medical problems?

☐ Hypertension/High Blood Pressure Yes/No
☐ Coronary Artery Disease Yes/No
☐ StrokeYes/No Yes/No
☐ Other (Please describe below)

☐ Glaucoma Yes/No
☐ Diabetes Yes/No

OPERATIONS

Please list all surgeries including approximate date or year.

Surgery	Diagnosis	Date/Yr.

MEDICATIONS

Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date.

Name of Drug	Strength	Frequency Taken	Start Date/Yr.

ALLERGIES

Please list all drug allergies including type of reaction.

Drug	Type Reaction

PERSONAL HISTORY AND HEALTH HABITS

Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow
Religion	
Occupation	
Children	How many male? ______ How many female? ______

REVIEW OF SYSTEMS (Check all that apply)

General	☐ Anorexia	☐ Chills	☐ Fatigue
	☐ Fever	☐ Malaise	☐ Sweats
	☐ Weight Loss		
Eyes	☐ Blurred Vision	☐ Double Vision	☐ Eye Pain
	☐ Eye Discharge	☐ Vision Loss	☐ Eye Irritation
Ears, Nose, and Throat	☐ Decreased Hearing	☐ Ringing in Ears	☐ Ear Pain
	☐ Hoarseness	☐ Pain with Swallowing	☐ Nose Bleeds
Cardiovascular	☐ Chest Pain	☐ Peripheral Edema	
	☐ Palpitations		
Respiratory	☐ Cough	☐ Wheezing	☐ Bloody Sputum
	☐ Shortness of Breath		
Gastrointestinal	☐ Abdominal Pain	☐ Nausea	☐ Vomiting
	☐ Diarrhea	☐ Constipation	☐ Tarry Stools
	☐ Bloody Stools		
Genitourinary	☐ Painful Urination	☐ Blood in Urine	☐ Sexual Dysfunction
	☐ Difficulty Voiding	☐ Urinary Incontinence	
Musculoskeletal	☐ Back Pain	☐ Joint Pain	☐ Joint Swelling
	☐ Muscle Weakness		
Skin	☐ Dryness	☐ Itching	☐ Rash
	☐ Suspicious Lesion		
Neurological	☐ Dizziness	☐ Weakness	☐ Tremors
	☐ Seizures		
Psychiatric	☐ Depression	☐ Anxiety	☐ Memory Loss
	☐ Hallucinations		
Endocrine	☐ Cold Intolerance	☐ Heat Intolerance	☐ Increased Thirst
	☐ Weight Change		
Hematologic and Lymphatic	☐ Abnormal Bruising	☐ Easy Bleeding	☐ Enlarged Lymph Nodes
Allergic and Immunologic	☐ Hay Fever	☐ Itching	☐ HIV Exposure

CERTIFICATION

The above information is true to the best of my knowledge.

X		
	Patient/Legal Guardian/Authorized Person (Signature)	Date of Signature