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.** ____

<u>Past Medical History</u>

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

<u>Family History</u>

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: ___________________________________

<u>Social History</u>

Marital Status: _______________________Number of children:_____________
Working / Retired Type of Work _______________________________

<u>Past Urologic History</u>

Have you ever had: (circle yes or no)

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

<u>Gynecologic History (women only)</u>

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_______________

Coastal Health Partners

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					
Too Hot/Cold	Yes	No		**Hematologic/Lymphatic**			
Tired/Sluggish	Yes	No		Swollen glands	Yes	No	
Other				Blood clotting problem	Yes	No	
Gastrointestinal				Other			
Abdominal pain	Yes	No		**Psychologic**			
Nausea/Vomiting	Yes	No		Are you generally satisfied with your life?	Yes	No	
Indigestion/heartburn	Yes	No		Do you feel severely depressed?	Yes	No	
Other T				Have you considered suicide?	Yes	NO	
Cardiovascular				Other			
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	/ /