

## 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 problems (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 surgery 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.