



PATIENT HISTORY QUESTIONNAIRE

NAME	CHART #	DATE OF BIRTH	AGE	DATE
REASON FOR VISIT		NAME & ADDRESS OF REFERRING DOCTOR		

MEDICAL HISTORY GENITOURINARY	DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? Please check Yes or No
Frequent urination <input type="checkbox"/> Yes <input type="checkbox"/> No Urinating at night <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ Pain on urination <input type="checkbox"/> Yes <input type="checkbox"/> No Bloody urine <input type="checkbox"/> Yes <input type="checkbox"/> No Female Menstrual History: Age of Onset _____ Date of Last Period _____ # of Pregnancies _____ # of Miscarriages _____ # of Abortions _____	Do you leak urine? <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney/Bladder Stones <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Tract Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Males Only: Rupture <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in ejaculate <input type="checkbox"/> Yes <input type="checkbox"/> No Pain in Testicle <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling of Testicle <input type="checkbox"/> Yes <input type="checkbox"/> No Erection Problems <input type="checkbox"/> Yes <input type="checkbox"/> No

PAST SURGERY (Include type, date, by whom): _____ _____ _____ _____ CURRENT MEDICATIONS (Include aspirin/blood thinners): _____ _____ _____ _____ DO YOU SMOKE? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount? _____ HAVE YOU EVER SMOKED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF SO, WHEN DID YOU STOP? _____	SERIOUS PAST ILLNESSES (Include cancer): _____ _____ _____ _____ ALLERGIES: _____ _____ _____ _____ USE ALCOHOL? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount? _____
---	--

FAMILY HISTORY				
MEMBER	SERIOUS ILLNESSES	AGE	LIVING?	CAUSE OF DEATH
Father			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Brothers			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sisters			<input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAL HISTORY General Review of Systems	DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? Please check Yes or No		
GENERAL: Weight loss or fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No EYES: Cataracts/other eye problems <input type="checkbox"/> Yes <input type="checkbox"/> No ENT: Ear, nose or throat conditions <input type="checkbox"/> Yes <input type="checkbox"/> No CARDIOVASCULAR: Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No RESPIRATORY: Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	GASTROINTESTINAL: Indigestion <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No Bowel Problems <input type="checkbox"/> Yes <input type="checkbox"/> No MUSCULOSKELETAL: Low Back Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No INTEGUMENTARY: Skin Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Other Skin Problems <input type="checkbox"/> Yes <input type="checkbox"/> No NEUROLOGICAL: Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No	PSYCHIATRIC: Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No ENDOCRINE: Sugar Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No Infertility <input type="checkbox"/> Yes <input type="checkbox"/> No HEMATOLOGIC/LYMPHATIC: Bleeding disorders <input type="checkbox"/> Yes <input type="checkbox"/> No ALLERGIC/IMMUNOLOGIC: Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	

PROSTATE SCREENING QUESTIONNAIRE - FOR MEN ONLY							
Please circle the answer that best represents your response to each of the following questions. The questions are designed to gauge the severity of any symptoms you may be experiencing.	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always	Patient Score
1. Incomplete emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?	0	1	2	3	4	5	
2. Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	0	1	2	3	4	5	
3. Intermittency: Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining: Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. Nocturia: Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
QUALITY OF LIFE DUE TO URINARY SYMPTOMS	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6