IDAHO UROLOGIC INSTITUTE

# Health History Questionnaire

Name: _____ DOB: _____ Today's Date: _____

Your Occupation: _____ Primary Care Physician: _____ **Preferred Pharmacy:** _____

Reason for visit: _____ When did symptoms first occur? _____

Have you seen another physician for this problem? ❑ Yes ❑ No Who? _____ When? _____

**Allergies:** Environmental / Food / Medications Please list, including reactions. ❑ **No known allergies**

_____

_____

_____

**Current medication**: Please List: Including prescriptions and over the counter supplements with dosage: ❑ **No Medications**

_____

_____

_____

**Surgical History:** Please list surgeries with dates. ❑ **No Surgical History**

| When/Year | Surgery | When/Year | Surgery |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**TOBACCO USE**: Please List Past or Current Use of Cigarettes/ Cigars/Chewing Tobacco/Electronic Cigarettes

How much? _____ Age started? _____ Age quit? _____

**ALCOHOL USE** : How much? _____ How often_____

**Please mark with an (X) any of the following illnesses and medical problems you have. Please include details and indicate the year when each started. If you are not certain when the illness started, write down the approximate year.**

| (X) Illness | Details/Type | Year |
|---|---|---|
| ❑ Chest Pain/Angina | | |
| ❑ Arthritis: | Type: | |
| ❑ Asthma | | |
| ❑ Bladder Outlet Obstruction/ BPH: | | |
| ❑ Heart Problems: | Type: | |
| ❑ Defibrillator ❑ Pacemaker | | |
| ❑ Cancer | Type: | |
| ❑ Chronic Diseases: | Type: | |
| ❑ COPD | | |
| ❑ Constipation | | |
| ❑ Coronary Artery Disease: | | |
| ❑ Depression | | |
| ❑ Diabetes: | ❑ Type 1 ❑ Type 2 | |
| ❑ Elevated PSA: | | |
| ❑ Emphysema: | | |
| ❑ Fibromyalgia | | |
| ❑ GERD | | |
| ❑ Gout | | |
| ❑ Hemorrhoids | | |
| ❑ Hepatitis: | Type: | |
| ❑ Valvular Heart Disease: | Type: | |
| ❑ OTHER: | | |

| (X) Illness | Details/Type | Year |
|---|---|---|
| ❑ High Cholesterol | | |
| ❑ High Blood Pressure | | |
| ❑ Incontinence: | Type: | |
| ❑ Kidney Disease : | Type: | |
| ❑ Kidney Stones: | Type: | |
| ❑ MRSA Infection: | Location: | |
| ❑ Obstructive Sleep Apnea | | |
| ❑ CPAP ❑ BiPAP | | |
| ❑ Prostate Cancer: | Type: | |
| ❑ Pulmonary Disease: | Type: | |
| ❑ Rectal Pain/ Sores: | | |
| ❑ Seizure Disorder : | Type: | |
| ❑ Stomach Problems : | Type: | |
| ❑ Stroke: | Type: | |
| ❑ TIA: | Type: | |
| ❑ Thyroid Disease: | Type: | |
| ❑ Trauma : | Type: | |
| ❑ Urinary Problems: | Type: | |
| ❑ Urinary Tract Infection: | | |
| ❑ Ulcer : | Type: | |
| ❑ Venereal Disease | | |

**FAMILY HEALTH HISTORY**

Are your parents living? ❑ Yes ❑ No : AGE (Mother) _____ (Father) ____ Any Urologic Cancers: ❑ Yes ❑ No _____

List any pertinent Health Problems:_____

If Deceased, List Age at death and cause of death: (Mother) _____(Father): _____

How many siblings do you have? BROTHERS: _____ SISTERS?_____

List any pertinent Health Problems:_____

Today's Date: _____

***Please fill out your current symptoms by marking Yes or No on the following questions.***

Patient Name: _____
Date of Birth: _____

## Systemic Symptoms

| | | |
|---|---|---|
| Feeling Tired | ❑ Yes | ❑ No |
| Chills | ❑ Yes | ❑ No |
| Fever | ❑ Yes | ❑ No |
| Weight Change: Gain or Loss (please circle) | #_____ | |
| Other _____ | | |

## Skin Symptoms

| | | |
|---|---|---|
| Skin Rash | ❑ Yes | ❑ No |
| Skin Itching | ❑ Yes | ❑ No |
| Skin Lesion: _____ | ❑ Yes | ❑ No |

## Eye Symptoms

| | | |
|---|---|---|
| Eye Pain | ❑ Yes | ❑ No |
| Halos Around Lights | ❑ Yes | ❑ No |
| Vision Changes | ❑ Yes | ❑ No |

## ENT & Mouth Symptoms

| | | |
|---|---|---|
| Hearing Loss | ❑ Yes | ❑ No |
| Ear Infection | ❑ Yes | ❑ No |
| Ringing in Ears | ❑ Yes | ❑ No |
| Nose Bleed | ❑ Yes | ❑ No |
| Dry mouth | ❑ Yes | ❑ No |
| Drainage in Back of Throat | ❑ Yes | ❑ No |
| Sore/Pain in Mouth | ❑ Yes | ❑ No |
| Sore Throat | ❑ Yes | ❑ No |

## Pulmonary Symptoms

| | | |
|---|---|---|
| Cough: New or Chronic (please circle ) | ❑ Yes | ❑ No |
| Productive Cough | ❑ Yes | ❑ No |
| Shortness of Breath | ❑ Yes | ❑ No |
| Wheezing | ❑ Yes | ❑ No |

## Cardiovascular Symptoms

| | | |
|---|---|---|
| Chest Pain or Discomfort | ❑ Yes | ❑ No |
| Irregular or Rapid Heart Beat | ❑ Yes | ❑ No |
| Difficulty Breathing with Exertion | ❑ Yes | ❑ No |
| Leg Pain or Swelling | ❑ Yes | ❑ No |

## Gastrointestinal Symptoms

| | | |
|---|---|---|
| Difficulty Swallowing | ❑ Yes | ❑ No |
| Heartburn | ❑ Yes | ❑ No |
| Nausea/Vomiting (please circle) | ❑ Yes | ❑ No |
| Change in Appetite | ❑ Yes | ❑ No |
| Abdominal Pain | ❑ Yes | ❑ No |
| Bloating | ❑ Yes | ❑ No |
| Diarrhea | ❑ Yes | ❑ No |
| Constipation | ❑ Yes | ❑ No |
| Recent Change in Bowels | ❑ Yes | ❑ No |
| Red Rectal Bleeding | ❑ Yes | ❑ No |
| Black Stools | ❑ Yes | ❑ No |

| | | |
|---|---|---|
| **MRSA: Date/Location:_____** | ❑ **Yes** | ❑ **No** |
| **C Diff: Date/Location:_____** | ❑ **Yes** | ❑ **No** |

## Genitourinary Symptoms

| | | |
|---|---|---|
| Loss of Bladder Control | ❑ Yes | ❑ No |
| Burning or Painful Urination | ❑ Yes | ❑ No |
| Urinary Frequency | ❑ Yes | ❑ No |
| Urinary Urgency | ❑ Yes | ❑ No |
| Nighttime urination: No. of times_____ | ❑ Yes | ❑ No |
| Blood in Urine | ❑ Yes | ❑ No |
| Frequent Urinary Tract Infections | ❑ Yes | ❑ No |
| Inability to empty bladder | ❑ Yes | ❑ No |
| Urinary Stream Changes: _____ | ❑ Yes | ❑ No |
| Urethral Discharge or Hx of STD | ❑ Yes | ❑ No |
| Kidney Pain or History of Kidney Stones | ❑ Yes | ❑ No |
| Difficulty with Erections | ❑ Yes | ❑ No |

## Musculoskeletal Symptoms

| | | |
|---|---|---|
| Joint Pain: _____ | ❑ Yes | ❑ No |
| Joint Redness or Swelling: _____ | ❑ Yes | ❑ No |
| Back Pain | ❑ Yes | ❑ No |
| Muscle Weakness or Wasting | ❑ Yes | ❑ No |
| Other _____ | | |

## Neurological Symptoms

| | | |
|---|---|---|
| Memory Loss | ❑ Yes | ❑ No |
| Numbness or Tingling of the Limbs | ❑ Yes | ❑ No |
| Difficulty Walking | ❑ Yes | ❑ No |
| Dizziness | ❑ Yes | ❑ No |
| Passing Out | ❑ Yes | ❑ No |
| Seizure | ❑ Yes | ❑ No |
| Tremors | ❑ Yes | ❑ No |
| Headache | ❑ Yes | ❑ No |
| Loss of Bowel Control | ❑ Yes | ❑ No |

## Psychological Symptoms

| | | |
|---|---|---|
| Anxiety | ❑ Yes | ❑ No |
| Depression | ❑ Yes | ❑ No |
| Hallucinations | ❑ Yes | ❑ No |
| Suicidal Thoughts | ❑ Yes | ❑ No |
| Change in Sleep Pattern | ❑ Yes | ❑ No |

## Endocrine Symptoms

| | | |
|---|---|---|
| Hot Flashes | ❑ Yes | ❑ No |
| Excessive Thirst | ❑ Yes | ❑ No |
| Cold Intolerance | ❑ Yes | ❑ No |

## Hematological / Lymphatic Symptoms

| | | |
|---|---|---|
| Bruising or Bleeding easily | ❑ Yes | ❑ No |
| Blood Clotting problems | ❑ Yes | ❑ No |
| Swollen Glands | ❑ Yes | ❑ No |

## Obstetrics and Gynecology

| | | |
|---|---|---|
| Abnormal Menstrual Periods | ❑ Yes | ❑ No |
| Menopause | ❑ Yes | ❑ No |
| Last Menstrual Period: _____ | | |
| Currently Pregnant: | ❑ Yes | ❑ No |
| No. of Pregnancies_____No. of Children_____ | | |
| Abnormal Vaginal Bleeding | ❑ Yes | ❑ No |
| Painful Intercourse | ❑ Yes | ❑ No |