IDAHO UROLOGIC INSTITUTE

Health History Questionnaire

Name: _____DOB_____
Today's Date_____
Your Occupation: _____
Primary Care Physician_____
Preferred pharmacy:_____

REASON FOR VISIT:_____
Have you seen another physician for this problem?
If yes, whom and when**?**_____

Allergies (Medication/Environmental/Food): Please list and include reaction:

_____
_____
_____
_____

Current Medications: (Please list prescription and over the counter medications. Include dosage):

_____
_____
_____
_____
_____
_____

Past Medical History: Circle any medical problems you have had in the past (include year of diagnosis)

- **Cancer** _____
  - Bladder _____ Prostate_____
  - Kidney_____ Breast _____
  - Lung _____ Colon_____
  - OTHER (Specify)_____
- **Heart disease** Cardiologist:_____
  - Heart attack (date/treatment)_____
  - CABG x _____ Stent x _____
  - Coronary artery disease _____
  - Congestive heart failure _____
  - Irregular heart rhythm/Afib_____
  - Valve disorder _____
  - Pacemaker_____ Defibrillator_____
- **Peripheral vascular disease**
- **High blood pressure**
- **High cholesterol**
- **Diabetes** last HbA1c_____(date)_____
- **Thyroid disease** _____
- **Neurological disease (circle)**
  - TIA, Stroke, Seizure, Dementia
- **Kidney stones:** _____
- **Kidney disease/failure**
  - Nephrologist _____
- **UTIs** (clinic or hospital to obtain culture results)
  - _____
- **Liver disease**: _____
  - Hepatitis
- **GI (circle)**
  - Inflammatory bowel disease, Constipation, Diarrhea, GERD, Ulcers
- **Pulmonary (circle)**
  - COPD/Emphysema,
  - Obstructive sleep apnea (CPAP, BIPAP)
- **Hematology** _____
  - Clotting disorder
- **Depression or Anxiety**
- **Substance abuse**
  - Alcohol, IV drugs
- **Infectious disease (circle)**
  - TB, HIV/AIDS, STDs, Drug resistant infections
- **Orthopedic/Spine problems**
  - _____
  - _____

Past Surgical History:

Year	Surgery	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

Age of Mother _____ Age of father _____

If deceased: Age of death and cause
(mother)_____ (father) _____

Any urologic cancer (Yes) (No) Type: _____

Pertinent health problems_____

Number of (brothers)_____(sisters)_____

Pertinent health problems_____

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Name:_____DOB___/_____/_____ Today's Date____/_____/_____

Social History:

Your Occupation: _____

Marital Status (Please Circle): Single Married Divorced Widowed Partner Remarried

Tobacco: How much?_____ Age started?_____ Age quit?_____ Do you use illicit drugs? Circle: Yes No

Type (Please Circle): Cigarettes Chewing Tobacco Smokeless tobacco

Alcohol Use: Circle: Yes No Servings daily? _____Servings weekly?_____

Who do you live with?_____ Name of skilled facility if applicable_____

Infection History: C Diff Infection: Date:_____ **MRSA Infection:** Date_____ Location?_____

Review of Systems *Please check any current problems / symptoms*

Category	Issues	No Problems
General	☐appetite change ☐chills ☐sweats ☐fatigue ☐fever ☐weight loss __#_____☐weight gain ☐weakness ☐hot flashes	☐
Genitourinary	☐painful urination ☐increased frequency ☐urinary urgency ☐blood in urine ☐urinary leakage ☐urinary tract infections ☐kidney stones ☐urinating at night (# of times_____) ☐urinary retention	☐
Male reproductive	☐testicular pain ☐swelling ☐sexual dysfunction	☐
Female reproductive	☐pelvic pain ☐menopause ☐abnormal bleeding ☐painful intercourse ☐Last menstrual period_____ ☐Currently pregnant Number of pregnancies_____ Number of children_____	☐
Skin	☐itching ☐rash ☐mole change	☐
Breast	☐breast mass ☐breast tenderness ☐nipple discharge	☐
Eyes	☐vision change ☐cataracts ☐glaucoma	☐
Ears, nose, mouth	☐dizziness ☐ringing in the ears ☐hoarseness	☐
Lungs	☐choking ☐cough ☐shortness of breath ☐coughing blood ☐wheezing	☐
Heart	☐chest pain ☐palpitations ☐fainting ☐leg pains ☐leg swelling	☐
Gastrointestinal (GI)	☐abdominal pain ☐difficulty swallowing ☐nausea ☐vomiting ☐diarrhea ☐constipation ☐jaundice (yellow appearance of skin) ☐black stools ☐blood in stool ☐hemorrhoids	☐
Musculoskeletal	☐arthritis ☐stiffness ☐weakness ☐backache	☐
Nervous System	☐dizziness ☐seizures ☐headaches ☐tremors ☐memory loss ☐paralysis ☐numbness ☐tingling ☐anxiety ☐depression ☐personality change ☐suicidal thoughts	☐
Hematologic/Lymphatic	☐bruising ☐easy bleeding ☐recurrent infections ☐groin node enlargement or tenderness ☐neck lymph node enlargement	☐

Printed name of person completing this form if not the patient:_____ Date____/____/____