IDAHO UROLOGIC INSTITUTE

Health History Questionnaire

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

Primary Care Physician: _____ Occupation: _____

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

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

When was your last physical exam? _____

Do you have allergies to food or medications? Please list, including reactions. ❑ **No known allergies**

Environmental / Food / Medications	**Reaction**

Please list current medications: Preferred Pharmacy: _____

Medications ❑ **No Medications**	**Dosage**	**Prescribing MD**

Please list all the times you have been admitted to the hospital for illness or surgery. ❑ **No Surgical History**

Year	**Surgery**	**Physician**

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

(X) **Illness**	**Year**	(X) **Illness**	**Year**
❑ Angina		❑ Hyperlipidemia	
❑ Arthritis		❑ Hypertension	
❑ Asthma		❑ Incontinence	
❑ Bladder Outlet Obstruction/BOO		❑ Kidney Disease	
❑ BPH		❑ Kidney Stones	
❑ Heart Problems		❑ MRSA	
❑ Cancer		❑ Prostate Problems	
Type: _____		❑ Elevated PSA	
❑ Chronic Diseases		❑ Pulmonary Disease	
Type: _____		❑ Rectal Pain	
❑ Constipation		❑ Rectal Sores	
❑ Coronary Artery Disease		❑ Seizure Disorder	
❑ Depression		❑ Stomach Problems	
❑ Diabetes		❑ Thyroid Disease	
❑ Duodenal Ulcer		❑ Trauma – Genital	
❑ Emphysema		❑ Trauma – Massive	
❑ Fibromyalgia		❑ Urinary Problems	
❑ GERD		❑ Urinary Tract Infection	
❑ Hemorrhoids		❑ Ulcer	
❑ Hepatitis		❑ Valvular Heart Disease	
❑ Smoke or chew tobacco		❑ Venereal Disease	
Packs/Cans per day		❑ Drink Alcohol	
Age started		How much?	
Age quit		How often?	

Your Family's Health History – Information needed on immediate family only.

Relationship	**Age, if living**	**Age at death**	**State of health or cause of death**	
Father			❑ Good	❑ Other _____
Mother			❑ Good	❑ Other _____
Brother (s)			❑ Good	❑ Other _____
			❑ Good	❑ Other _____
			❑ Good	❑ Other _____
Sister (s)			❑ Good	❑ Other _____
			❑ Good	❑ Other _____
			❑ Good	❑ Other _____

CONTINUED ON BACK SIDE

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	❑ Yes	❑ No
Loss _____		
Gain _____		

Skin Symptoms

Skin Rash	❑ Yes	❑ No
Skin Itching	❑ Yes	❑ No
Change in Color of Skin	❑ Yes	❑ No

Eye Symptoms

Eye Pain	❑ Yes	❑ No
Halos Around Lights	❑ Yes	❑ No

ENT & Mouth Symptoms

Hearing Loss	❑ Yes	❑ No
Earache	❑ Yes	❑ No
Lump in the Throat	❑ Yes	❑ No
Drainage in Back of Throat	❑ Yes	❑ No
Ringing in Ears	❑ Yes	❑ No
Sore/Pain in Mouth	❑ Yes	❑ No
Sore Throat	❑ Yes	❑ No

Pulmonary Symptoms

Chronic Cough	❑ Yes	❑ No
Difficulty Breathing	❑ Yes	❑ No

Cardiovascular Symptoms

Chest Pain or Discomfort	❑ Yes	❑ No
Irregular or Rapid Heart Beat	❑ Yes	❑ No
Difficulty Breathing with Exertion	❑ Yes	❑ No

Genitourinary Symptoms

Urinary Loss of Control	❑ Yes	❑ No
Burning Urination	❑ Yes	❑ No
Painful Urination	❑ Yes	❑ No
Erectile Disorder	❑ Yes	❑ No
Urinary Frequency	❑ Yes	❑ No
Blood in Urine	❑ Yes	❑ No
Trouble Passing Urine	❑ Yes	❑ No
Flank Pain	❑ Yes	❑ No
Inguinal Swelling	❑ Yes	❑ No

Obstetrics and Gynecology

Menstrual Periods Abnormal	❑ Yes	❑ No
Breast Lump	❑ Yes	❑ No
Menopause	❑ Yes	❑ No
Last Menstrual Period	_____	
Number of Pregnancies	_____	
Number of Children	_____	
Age at First Pregnancy	_____	
Currently Pregnant	❑ Yes	❑ No

Gastrointestinal Symptoms

Difficulty Swallowing	❑ Yes	❑ No
Red Rectal Bleeding	❑ Yes	❑ No
Black Stools	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Recent Change in Bowels	❑ Yes	❑ No
Abdominal Pain	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Change in Appetite	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No
Bloating	❑ Yes	❑ No

Musculoskeletal Symptoms

Hip Pain	❑ Yes	❑ No
Joint Stiffness	❑ Yes	❑ No
Joint Pain	❑ Yes	❑ No
Back Pain	❑ Yes	❑ No
Difficulty Walking	❑ Yes	❑ No
Ankle Swelling	❑ Yes	❑ No
Foot Swelling	❑ Yes	❑ No

Neurological Symptoms

Memory Loss	❑ Yes	❑ No
Tingling of the Limbs	❑ Yes	❑ No
Poor Coordination	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Fainting	❑ Yes	❑ No
Convulsions	❑ Yes	❑ No
Weakness in Limbs	❑ Yes	❑ No
Headache	❑ Yes	❑ No

Psychological Symptoms

Mood	❑ Yes	❑ No
Sleep Disturbances	❑ Yes	❑ No
Depression	❑ Yes	❑ No

Endocrine Symptoms

Hot Flashes	❑ Yes	❑ No
Excessive Thirst	❑ Yes	❑ No
Feeling of Weakness	❑ Yes	❑ No

Hematological Symptoms

Bleed Easily	❑ Yes	❑ No
Easy Bruising Tendency	❑ Yes	❑ No
Swollen Gland in the Neck	❑ Yes	❑ No