Adult Health History Questionnaire

IDAHO UROLOGIC INSTITUTE

SURGERY CENTER OF IDAHO

Today's Date: _____ Pharmacy: _____

Name: _____DOB: _____

Reason for Visit: _____Primary Care Physician: _____

Have you been seen for this before? (Y / N) _____ All Physicians involved in your care: _____

Do you currently have any pain related to your diagnosis? (Y / N) how would you rate your current pain 0-10? _____

ALLERGIES: Do you have an allergy or have sensitivity to latex or rubber products? (Y / N) □ **No known allergies**

Environmental / Food / Medications:	Reaction:
_____	_____
_____	_____

MEDICATIONS Please include all over the counter medications □ See Medication List □ **No Medications**

_____ _____

_____ _____

_____ _____

SURGICAL HX & HOSPITALIZATIONS: Please list hospital stays due to illness and / or surgery: □ See Surgical History List □ **No surgical history**

_____ _____

_____ _____

SOCIAL HISTORY Marital Status _____ Occupation: _____

□ Smoke, chew tobacco, or vape □ Drink Alcohol □Recreational /Street Drugs (Y / N)

Packs / cans per day: _____ How much: _____ Type: _____

Age started/quit: _____ How often: _____ Where do you live: Home or Skilled nursing

FAMILY HISTORY: Any history of urologic cancers? (Y / N) Type and Whom: _____

Mother: Age of Death: _____ Pertinent health problems: _____ Cancer (Y / N) Type: _____

Father: Age of Death: _____ Pertinent health problems: _____ Cancer (Y / N) Type: _____

Do you use? □ Glasses □ Contacts □ Hearing Aids □Dentures □ Partials □ Dental Implants □ Cane □Walker □Wheelchair

Do you have any of the following **medical problems**? If yes, please place an "x" in the circle next to the problem.

HEART	LUNG	GASTROINTESTIONAL	GENITOURINARY
o Murmur	o Asthma	o Hiatal hernia	o Retention/Catheter
o Irregular heartbeat	o Emphysema / COPD	o Reflux / GERD	o Incontinence
o High blood pressure	o Pneumonia	o Ulcer	o Kidney stones
o High Cholesterol	o Tuberculosis	o Liver Disease	o Kidney Disease
o Heart failure	o Sleep apnea	o Inflammatory Bowel Disease	o UTI
o Heart attack	o Use CPAP / home oxygen	o Hepatitis A B C	o Erectile dysfunction
o Anemia	o Nebulizer		o Low Testosterone
o bleeding or clotting disorder Type:	**NEUROLOGICAL**	**CANCER**	o Sterilization procedure
	o Seizures	o Breast cancer	**MUSCLE/JOINT/AUTOIMMUNE**
o Peripheral Vascular Disease	o Stroke or TIA	o Kidney cancer	o Arthritis
o CABG x ___	o Multiple Sclerosis	o Prostate cancer	o Lupus
o Stent x _____	o ALS	o Bladder cancer	o Rheumatoid Arthritis
o Blood Clot (PE/DVT)	oMyasthenia gravis	o Colon cancer	**ENDOCRINE**
IMPLANTABLE DEVICES	o Spinal Cord Injury level ____	o Lung cancer	o Thyroid disease
o Defibrillator	o Dementia / Alzheimer's	o Other cancer	o Diabetes
o Pacemaker	**INFECTIOUS DISEASE**	**EYE**	
o Shunt	o Exposure to HIV / AIDS	o Glaucoma	
o Vagal Stimulator	o **C Diff Date:**	o Macular Degeneration	
	o **MRSA Date location:**		

Have you or a family member undergone general anesthesia AND had a reaction with the anesthesia? Malignant Hyperthermia? (Y / N)

If yes please describe: _____

FORM COMPLETED BY Signature: _____Date: _____

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REVIEW OF SYSTEMS

Review of Systems ***Please check any current problems / symptoms within the last 30 days***

General ☐ **NO PROBLEMS**	☐appetite change ☐fever ☐chills ☐fatigue ☐weight loss _____ ☐weight gain _____ ☐hot flashes	**Genitourinary** ☐ **NO PROBLEMS**	☐painful urination ☐increased frequency ☐urinary urgency ☐blood in urine ☐urinary leakage ☐urinary tract infections ☐kidney stones ☐urinating at night (# of times___) ☐urinary retention
Heart ☐ **NO PROBLEMS**	☐chest pain ☐palpitations ☐fainting ☐leg swelling	**Male reproductive** ☐ **NO PROBLEMS**	☐testicular pain ☐swelling ☐sexual dysfunction Number of children_____
Lungs ☐ **NO PROBLEMS**	☐cough ☐shortness of breath ☐recent cold ☐wheezing ☐Sleep Apnea CPAP	**Female reproductive** ☐ **NO PROBLEMS**	☐pelvic pain ☐menopause ☐painful intercourse ☐Last menstrual period_____ ☐Currently pregnant Number of pregnancies_____
Gastrointestinal (GI) ☐ **NO PROBLEMS**	☐abdominal pain ☐nausea & vomiting ☐diarrhea ☐constipation ☐black stools ☐blood in stool	**Musculoskeletal** ☐ **NO PROBLEMS**	☐numbness / tingling ☐muscle cramps ☐weakness ☐bone pain
Eyes Ears Nose Mouth ☐ **NO PROBLEMS**	☐vision change ☐dizziness ☐ringing in the ear ☐hoarseness	**Nervous / Psychiatric** ☐ **NO PROBLEMS**	☐headaches ☐memory loss ☐paralysis ☐anxiety ☐depression
Skin ☐ **NO PROBLEMS**	☐itching ☐rash ☐open wound/poor healing	**Hematologic/Infectious** ☐ **NO PROBLEMS**	☐bruising ☐easy bleeding ☐recurrent infections ☐C Diff Date: _____ ☐MRSA Date: _____
Breast ☐ **NO PROBLEMS**	☐breast mass ☐breast tenderness		

Internal Use Only

Surgery Center Reviewed by Sign and Date: _____