

Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Gender: \_\_\_\_\_

**New Patient Questionnaire**

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**PAST MEDICAL HISTORY**

List all medical illnesses.

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**OB HISTORY**

Number of pregnancies \_\_\_\_\_ Number of deliveries \_\_\_\_\_

**GENERAL SURGERY**

List all operations you have had.

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**MEDICATIONS**

List all medications you take and the dosage.

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Do you take ASPIRIN daily? Yes \_\_\_\_\_ No \_\_\_\_\_

**ALLERGIES**

List all allergies to medications.

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**FAMILY HISTORY**

Have any members of your family had urologic problems? Yes \_\_\_\_\_ No \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Occupation \_\_\_\_\_

Have you ever smoked cigarettes/cigars/pipe? NO YES How much? \_\_\_\_\_

Do you drink alcohol? NO YES How much? \_\_\_\_\_

Patient Name:

DOB:

Age:

Gender:

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Date /TodayLong

**REVIEW OF SYSTEMS**

**GENERAL**

Weight change? YES NO  
Change in mobility/activity? YES NO  
Change in energy level? YES NO  
Fever/chills? YES NO

**EYES**

Visual changes? YES NO  
Double vision? YES NO  
Glaucoma/cataracts? YES NO

**EAR/NOSE/THROAT**

Hearing loss or ringing in the ears? YES NO  
Recurrent nosebleeds? YES NO  
Bleeding gums? YES NO  
Hoarseness? YES NO  
Significant sinus congestion? YES NO

**RESPIRATORY**

Shortness of breath? YES NO  
Frequent cough? YES NO  
Wheezing? YES NO  
Recent Upper Respiratory Infection? YES NO  
Coughing up blood? YES NO

**CARDIAC**

Chest pain? YES NO  
Palpitations? YES NO  
Shortness of breath on exertion? YES NO  
Shortness of breath during sleep? YES NO

**GASTROINTESTINAL**

Abdominal pain? YES NO  
Nausea/vomiting? YES NO  
Bloating? YES NO  
Diarrhea? YES NO  
Constipation? YES NO  
Blood in stool? YES NO  
Black stool? YES NO

**MUSCULOSKELETAL**

Joint pain? YES NO  
Joint swelling/inflammation? YES NO  
Range in motion changes? YES NO  
Back pain? YES NO

**NEUROLOGICAL**

Dizziness? YES NO  
Blackouts? YES NO  
Problems with memory? YES NO  
Problems with vision/speech/touch? YES NO  
Problems with gait/balance? YES NO  
Seizures? YES NO

**SKIN**

Chronic rash? YES NO  
Non-healing lesions? YES NO

**PSYCHIATRIC**

Nervousness? YES NO  
Mood changes? YES NO  
Depression? YES NO

**ENDOCRINE**

Thyroid trouble? YES NO  
Hot or cold intolerance? YES NO  
Excessive thirst? YES NO  
Excessive hunger? YES NO

**HEMATOLOGIC/LYMPHATIC**

Anemia? YES NO  
Easy bruising/bleeding? YES NO  
Swollen lymph nodes? YES NO

**ALLERGIC/IMMUNOLOGIC**

Hay fever? YES NO  
Environmental allergies? YES NO  
Chronic immune problems? YES NO