

CENTRAL MARYLAND UROLOGY ASSOCIATES, PA
UROLOGY PATIENT QUESTIONNAIRE (PAGE 1 OF 2)

Date: _____
Name: _____ DOB: _____ Age: _____
Referring Physician: _____

The following information is **CONFIDENTIAL**. Information contained here will not be released to anyone without your authorization to do so.

CHIEF COMPLAINT

1. What is the main reason you are seeing the doctor today? If it is for prostate related symptoms, please fill out the American Urological Score Sheet which may describe the quality and severity of your symptoms.

15. Do you have any other significant medical problems? Please list:

a) _____ b) _____ c) _____

16. List all of the surgeries you have ever had: a) _____ b) _____
c) _____ d) _____ e) _____

17. Are you **ALLERGIC** to any medications? a) _____ b) _____
c) _____ d) _____ e) _____

18. List the NAMES (and DOSE if known) of the medications you take daily, including Aspirin:

a) _____ b) _____ c) _____
d) _____ e) _____ f) _____

19. Have you ever had a blood transfusion? Yes _____ No _____

SOCIAL HISTORY

7. Are you: single _____ married _____ widowed _____ separated _____ other _____

8. Do you have a living will? Yes _____ No _____

9. What is your occupation? _____

10. Do you smoke cigarettes? Yes _____ No _____ How much? _____ How often? _____

11. Do you drink alcohol? Yes _____ No _____ How much? _____ How often? _____

12. Caffeine use? 1-2 cups/day _____ >3 cups /day _____

FAMILY HISTORY (*Have you or any member of your family had cancer or any other disease of the kidney, bladder, prostate or testicles?*)

Father _____ Mother _____ Brother _____ Sister _____ Children _____ Self _____

UROLOGY PATIENT QUESTIONNAIRE (page 2 of 2)

Patient's Name: _____ **Date:** _____

Do you now, or have you ever had any problems related to the following systems? Please circle.

1. General – Any changes in:

- Appetite
- Weight
- Chills
- Fever
- Sweat

2. Head

- Chronic Headaches
- Head Trauma

3. Eyes

- Visual Changes
- Double Vision
- Blurred Vision

4. Ears, Mouth, Nose, Throat

- Ear Ringing
- Hearing Loss
- Bleeding from Nose or Gums
- Chronic Hoarseness

5. Lungs

- Chronic Cough
- Shortness of Breath
- Wheezing
- Asthma

6. Heart

- Chest Pain (Angina)
- Heart Murmurs (requiring antibiotic prophylaxis)
- Heart Attack

7. Gastro-intestinal

- Chronic Nausea or Vomiting
- Chronic Diarrhea
- Chronic Constipation
- Rectal Bleeding
- Ulcers

8. Genito-urinary

- Bleeding
- Chronic Urinary Infections
- Incontinence
- Infertility
- Kidney Stones
- Frequent Urination

9. Muscular-skeletal

- Chronic Pain
- Muscle Weakness
- Joint Swelling
- Backache

10. Neurological

- Chronic Dizziness
- Stroke
- Seizures

11. Skin

- Chronic Rashes
- Non-healing Ulcers

12. Psychiatric

- Increased Nervousness
- Mood Changes
- Chronic Depression

13. Endocrine

- Thyroid problems
- Heat or Cold Intolerance
- Diabetes
- Excessive Thirst
- Excessive Hunger

Please explain any other condition if not mentioned above:
