



# Patient Questionnaire

**This document provides your physician with critical information regarding your medical history. Please complete this questionnaire prior to your visit and bring it with you to your appointment.**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

### Pharmacy Information

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**The following information is confidential. It will not be released to anyone without your authorization.**

### Chief Complaint

What is the main reason you are seeing the doctor today? \_\_\_\_\_

### Have you had any tests done?:

**LABWORK** ( PSA, urine tests, semen tests, etc)  Yes  No

If YES, list test(s): \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

**RADIOLOGY** ( CT, KUB, IVP, MRI, sonogram, etc)  Yes  No

If YES, list test(s): \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

**Please be sure to bring all RADIOLOGY IMAGES with you at the time of your appointment. Contact the radiology facility for release of either the actual x-ray films or the images saved to a disc.**

List any other medical problems, including the use of a C-PAP machine and pacemaker:

a) \_\_\_\_\_ b) \_\_\_\_\_ c) \_\_\_\_\_ d) \_\_\_\_\_

List all surgeries you have had, including heart valve or joint replacement:

a) \_\_\_\_\_ b) \_\_\_\_\_ c) \_\_\_\_\_ d) \_\_\_\_\_

Are you allergic to any medications or latex? Please list:

a) \_\_\_\_\_ b) \_\_\_\_\_ c) \_\_\_\_\_ d) \_\_\_\_\_

List the names (and dose if known) of all medications you take daily, including aspirin:

a) \_\_\_\_\_ b) \_\_\_\_\_ c) \_\_\_\_\_ d) \_\_\_\_\_

e) \_\_\_\_\_ f) \_\_\_\_\_ g) \_\_\_\_\_ h) \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No

Do you take antibiotics prior to a dental visit?  Yes  No

**Social History**

- Marital status:  Single  Married  Separated  Divorced  Widowed
- Do you have a living will?  No  Yes
- Do you smoke cigarettes?  No  Yes, less then 1 pack a day  Yes, 1-2 packs a day
- Have you ever smoked tobacco?  No  Yes
- Do you drink alcohol?  No  Yes  Prior history of abuse
- What is your **daily** caffeine use:  None  1-2 cups  More than 3 cups

**Family History**

Have any members of your family had **cancer** or any other disease of the **kidneys, bladder, prostate, or testicles**? **Please specify:**

Father: \_\_\_\_\_ Son: \_\_\_\_\_  
 Mother: \_\_\_\_\_ Daughter: \_\_\_\_\_  
 Brother: \_\_\_\_\_ Grandfather: \_\_\_\_\_  
 Sister: \_\_\_\_\_ Grandmother: \_\_\_\_\_

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

**General**

- Fatigue
- Fever
- Night Sweats
- Itching
- Chills
- Weight Gain
- Weight Loss

**Skin**

- Ulcers
- Rash
- Itching
- Lesions

**Head**

- Chronic Headache
- Head Injury/Trauma

**Eyes**

- Visual Loss
- Double Vision
- Visual Disturbances

**Ear, Mouth, Nose, and Throat**

- Ear Ringing
- Nose Bleeds
- Bleeding from Gums
- Hoarseness
- Decreased Hearing

**Respiratory**

- Asthma
- Chronic Cough
- Wheezing
- Difficulty Breathing

**Heart**

- Chest Pain
- High Blood Pressure
- Heart Attack
- Heart Murmurs (requiring antibiotics)
- Pacemaker
- High Cholesterol/Triglycerides

**Gastrointestinal**

- Constipation
- Diarrhea
- Nausea
- Vomiting
- Rectal Bleeding

**Urinary**

- Bleeding
- Chronic Urinary Infections
- Incontinence
- Kidney Stones
- Frequency
- Urgency

**Muscular-Skeletal**

- Back Pain
- Joint Pain
- Joint Swelling
- Muscle Weakness
- Muscular Pain or Tenderness

**Neurological**

- Dizziness
- Seizures
- Stroke
- Tremor

**Psychiatric**

- Anxiety
- Depression
- Mood Changes

**Endocrine**

- Thyroid Problems
- Appetite Changes
- Heat or Cold Intolerance
- Diabetes
- Sexual Dysfunction

**Hematology**

- Anemia
- Easy Bruising
- Prolonged Bleeding

Please explain any other condition if it is not mentioned above:

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**Thank you for completing this questionnaire. Be sure to bring it with you to your appointment.**