COMMONWEALTH UROLOGY PATIENT QUESTIONNAIRE

Your Name: _________________________________ Your Age: ______ Today's Date: ________________

Dear Patient: A few minutes of your time carefully answering the following questions will help the urologist more accurately assess your problem and give you better care. Thank you!

- What is the name of the doctor who sent you for evaluation? ___________________________________
- What is the ***main reason*** you are seeing the doctor today? ______________________________________
- Have you ever seen a urologist before? YES _____ NO _____

I. HISTORY OF PRESENT ILLNESS:

1. For what length of time have you had this problem? ___________________________________
2. Where is the problem located?____
3. What signs or symptoms are you having?____
4. Does anything make the problem better or worse? _____________________________________
   Are you currently taking any medications to treat the symptoms?__________________________
5. Does the problem interfere with normal daily function? YES _____ NO _____
   If YES, explain: ____
6. How long does the problem last? CIRCLE: Seconds; Minutes; Hours; Days; All the time
7. On a scale of 1 - 10, with 10 being most severe, circle the number that best describes your problem:

1 2 3 4 5 6 7 8 9 10

II. REVIEWOF SYSTEMS:

- Do you have any of the following problems at this time? **CIRCLE if YES or NONE**
- Write in any additional problems you have that are not listed below.

Const. symptoms:	Fever	Chills	Headaches	Weight Loss	None
Eyes:	Eye Pain	Blurred Vision	Double Vision	Loss of Night Vision	None
Neurological:	Dizzy	Passing Out	Numbness	Seizures	None
Endocrine:	Too Hot	Too Cold	Excessive Thirst	Tired/Sluggish	None
Gastrointestinal:	Nausea	Indigestion	Vomiting	Abdominal Pain	None
	Diarrhea	Constipation	Blood In Stool	Stomach Ulcers	
Cardiovascular:	Chest Pain	Leg Cramps	Irregular Heartbeat	Palpitations	None
	Angina	Swollen Ankles	Varicose Veins		
Respiratory:	Wheezing	Frequent Cough	Coughing Up Blood	Shortness Of Breath	None
	Excessive Snoring		Must Sleep Sitting Up		
Skin:	Rash	Boils	Dry Skin	Moles/Abn Freckles	None
Musculoskeletal:	Joint Pain	Neck Pain	Back Pain	Arthritis	None
Blood/Lymphatic:	Anemia	Bleed Easily	Bruise Easily	Swollen Glands	None
Allergy/Immun:	Asthma	Hay Fever	Food Allergy	Other Allergies	None
Ear/Nose/Throat:	Sinus	Sore Throat	Hoarse Voice	Hearing Loss	None
Psychologic/Mental:	Nervous	Depression	Forgetful		None

Genitourinary:	Painful urination	Urinate too often	Slow urination	Nephritis	None
	Urinary incontinence	Urinary infection	Bladder trouble	Kidney disease	
	Dialysis	Kidney failure	Blood in the urine	Urinary problem as child	
	Kidney stones	Catheter	Urinary tract injury	Urinary surgery	

MEN: Prostate gland trouble Abnormal PSA Prostate biopsy Sexual Dysfunction

WOMEN: Abnormal periods Female hormone problem Uterus/Ovaries-problem
Could you be pregnant now? YES ____ NO ____; Are you on birth control now? YES ____ NO ____
Type of birth control: Pill ____ Other ____; Number of Pregnancies? ____; Number of Births? ____

III. PAST MEDICAL HISTORY:

1. Are you allergic to any medication? YES _____ NO _____ Latex? YES____ NO_____
If you are *allergic* to any medications, please list them:
(1) _______________________ (2) _______________________ (3) _______________________
(4) _______________________ (5) _______________________ (6) _______________________
2. List the NAMES (and DOSE if known) of the prescription medicine you take every day:
(1) _____________________________________ (2) _____________________________________
(3) _____________________________________ (4) _____________________________________
(5) _____________________________________ (6) _____________________________________
(7) _____________________________________ (8) _____________________________________
Do you take: ASPIRIN? YES __NO __;COUMADIN? YES __NO __;PLAVIX? YES __NO __
3. Do you take any non-prescription medications, nutritional supplements, vitamins or health food store medications? YES _____ NO _____
If YES, please list: ____
4. List all the *operations* or *surgery* you have ever had and *the date of the surgery*:
(1) _____________________________________ (2) _____________________________________
(3) _____________________________________ (4) _____________________________________
(5) _____________________________________ (6) _____________________________________
5. Have you ever had a blood transfusion? YES _____ NO _____
6. Have you ever had any of the following? CIRCLE if YES

Heart attack	Heart failure	Heart trouble	Pacemaker
High blood pressure	Stroke	Glaucoma	Sugar diabetes
Stomach ulcers	Tuberculosis	Seizures	Radiation therapy
Cancer	Trouble breathing	Problems with anesthesia	False teeth

7. Have you every had any other serious medical problems? YES _____ NO _____
If YES, please list: ____
8. Have you ever had cancer? If yes, explain_____________________

IV. FAMILY HISTORY:

1. Have any of the men in your family ever had prostate cancer? YES _____ NO _____
If YES, Circle: Father, Grandfather, Brother, Uncle, Cousin
2. Any other history of kidney or urinary tract disease in your family? YES _____ NO _____
3. Any other serious diseases in your family such as: TB _____ Diabetes _____ Cancer _____
Other: ____

V. SOCIAL HISTORY:

1. Are you on a special diet? YES ____ NO ____; If YES, What type?: _____________________
2. Do you use tobacco? YES ___ NO ___; CIRCLE: Cigarettes, Cigars, Pipe, Chew; No./day: ____
3. Do you drink alcohol? YES _____ NO _____ What type? __________ How much? __________
4. Are you: Single _______, Married _______, Divorced _______, Widowed _______
5. What is your occupation? ____

PHYSICIAN SIGNATURE: ____________________________M.D. DATE: ______________