Coastal Healthcare

Patient Questionnaire

(Updated Yearly)

Name_____Date of Birth_____Date_____
Name and address of primary care doctor:_____
Other doctors you currently see (Include name and specialty):

1. _____ **2.** _____
3. _____ **4.** _____

Past Medical History

A. List all medical conditions (e.g. heart disease, Heart attack, diabetes, high blood pressure, Stroke, emphysema, etc):

1. _____
2. _____
3. _____
4. _____

B. List all medications including aspirin, herbal supplements & vitamins. (continue on back if necessary):

1. _____
2. _____
3. _____
4. _____

C. List any surgeries you have had (and dates):

1. _____
2. _____
3. _____

D. List any allergies to medications:

1. _____
2. _____
3. _____

E. Do you currently smoke? Yes / No If yes, state how many packs per day and number of years. If you previously smoked and have quit, please also state year when you last smoked.

_____

F. Do you use alcohol? Yes / no If yes, state roughly how often. _____
Have you ever had a problem with excessive alcohol use ? yes / no

Family History

Do you have a family history of (circle all that apply): kidney stones, prostate cancer, bleeding problems, Kidney tumors, problems with anesthesia during surgery, diabetes, high blood pressure, heart problems, other: _____

Social History

Marital Status: _____Number of children:_____
Working / Retired Type of Work _____

Past Urologic History

Have you ever had: (circle yes or no)

1. trouble passing urine	yes / no	9. Prostate Surgery	yes / no
2. urinary tract infection	yes / no	10. prostate cancer	yes / no
3. blood in urine	yes / no	11. bladder or kidney surgery	yes / no
4. kidney stones	yes / no	12. sexually transmitted disease	yes / no
5. cystoscopy	yes / no	13. kidney problems or failure	yes / no
6. bladder tumor	yes / no	14. urinary incontinence (involuntary loss of urine)	yes / no
7. prostate enlargement	yes / no		
8. impotence (men only)	yes / no		

Gynecologic History (women only)

Date of last menstrual period:_____ Could you be pregnant? Yes / no
Number of pregnancies _____ # of children: _____ # vaginal deliveries _____ # C-sections____
History o (circle all that apply): endometriosis, cancer of cervix, uterus, or ovaries, pelvic radiation, hysterectomy, menopause, prolapse bulge in vagina.

Name: _____ DOB: _____

REVIEW OF SYSTEMS

Please check if you are currently having or have had a history of the following:

CONSTITUTIONAL

____ Excess Weight Loss
____ Excess Weight Gain
____ Fever
____ Exercise Intolerance
____ Night Sweats

ENT and EYES

____ Sore Throat
____ Snoring
____ Sinus Problems
____ Hearing Loss
____ Ear Pain
____ Nose Bleeding
____ Vision Changes
____ Dry Eyes

CARDIOVASCULAR

____ Chest Pain
____ Arm Pain w/exertion
____ Shortness of breath w/walking
____ Shortness of breath w/lying down
____ Palpitations
____ Heart Murmur

RESPIRATORY

____ Cough
____ Wheezing
____ Shortness of Breath
____ Coughing up Blood

GASTROINTESTINAL

____ Change in Appetite
____ Heartburn
____ Nausea
____ Vomiting
____ Constipation
____ Diarrhea
____ Blood in Stool
____ Abdominal Pain
____ Ulcers

GENITOURINARY

____ Incontinence
____ Blood in Urine
____ Frequency
____ Difficulty Urinating

MUSCULOSKELETAL

____ Swelling in Extremities
____ Back Pain
____ Joint Pain
____ Muscle Weakness
____ Muscle Aches

SKIN

____ Rashes
____ Abnormal Moles
____ Itching
____ Dry Skin
____ Jaundice

NEUROLOGICAL

____ Fainting
____ Muscle Weakness
____ Numbness
____ Headaches
____ Stroke
____ Dizziness
____ Seizures

PSYCHIATRIC

____ Depression
____ Sleep Disturbance
____ Feel Unsafe
____ Alcohol Abuse
____ Anxiety

ENDOCRINE

____ Fatigue

HEMATOLOGIC

____ Bruise Easily
____ Swollen Glands
____ History of Blood Clots

ALLERGIC

____ Runny Nose
____ Sinus Pressure
____ Itching
____ Hives
____ Frequent Sneezing

OTHER: (please list)

____ Steroid Use
____ Asthma
____ Heart Attack
____ High Blood Pressure
____ Thyroid Disease
____ Anemia

_____

_____

_____

_____