Medical History Questionnaire

Appointment Date: ______/______/_______ Your Name: ____

Date of Birth: ______/______/_______ Age: _____ Primary Care Physician: ________________________________

Reason for your visit: ____

On a scale of 1-10, how severe is the problem? (please circle) 1 2 3 4 5 6 7 8 9 10

Approximately when did you first notice the problem? ____

How long does the problem last? ____

Is the problem constant or variable? (please circle)

Does the problem interfere with your normal function? Yes: _____ No:_____

Does anything help the problem?____

Does anything make the problem worse? ____

Current Urinary Symptoms:

Hesitancy starting urinary stream	Yes/No	Urgency to urinate	Yes/No
Decreased force of stream	Yes/No	Burning sensation with urination	Yes/No
Interrupted stream	Yes/No	Increased frequency with urination (_______day)	Yes/No
Dribbling after urination	Yes/No	Getting up at night to urinate (________ times)	Yes/No
Blood in urine	Yes/No	History of kidney stones	Yes/No
Sensation of incomplete bladder emptying	Yes/No		

Urinary Incontinence Symptoms: (loss of urine)

With coughing, laughing, sneezing	Yes/No	With an urgency or warning prior	Yes/No
With activity or exercise	Yes/No	All the time	Yes/No
With standing up	Yes/No	Protective pads worn (_______pads/day)	Yes/No
While sleeping	Yes/No		

Current Medical Problems: (eg. diabetes, heart disease, kidney disease, cancer, arthritis, etc.)

Current Medications: (name and dosage)

Your Name: ____

Past Surgical History: (What type & approximately when)

Other Prior Hospitalizations: (When and Why?)

Allergies: Yes/No (If yes, please list allergies and type of reaction)

Social History:

Marital Status: Single Married Divorced Widowed Widowered		Occupation:
Do you drink alcohol?	Yes/No	How many years did you smoke?
If yes, how much?		How many packs per day?
Do you currently smoke?	Yes/No	When did you quit?
Have you smoked in the past?	Yes/No	

Family History:

Relative	Medical Problems (eg: diabetes, hypertension, heart disease, cancer, stroke, etc.)	Alive	Age
Father		Yes/No	
Mother		Yes/No	
		Yes/No	

Review of Systems: (Do you experience any of the symptoms below?

Fever/Chills	Y/N	Swelling feet or ankles	Y/N	Diarrhea	Y/N	Depression	Y/N
Weight change	Y/N	Shortness of breath	Y/N	Joint Swelling	Y/N	Tired/sluggish	Y/N
Double vision	Y/N	Wheezing	Y/N	Joint pain	Y/N	Excessive thirst	Y/N
Blurred vision	Y/N	Chronic cough	Y/N	Back pain	Y/N	Swollen glands	Y/N
Headaches	Y/N	Abdominal pain	Y/N	Rash	Y/N	Blood clotting problem	Y/N
Hearing loss	Y/N	Nausea/vomiting	Y/N	Itch	Y/N	Seasonal allergies	Y/N
Dizziness	Y/N	Indigestion	Y/N	Seizures	Y/N	Pain/discomfort with intercourse	Y/N
Sore throat	Y/N	Change in bowel habits	Y/N	Tremors	Y/N		
Chronic Sinus problem	Y/N	Blood in stools	Y/N	Dizziness	Y/N		
Chest pain	Y/N	Constipation	Y/N	Numbness/ tingling	Y/N		