

WAKE UROLOGICAL ASSOCIATES PA / NEW PATIENT QUESTIONNAIRE

DATE: _____ NAME: _____ AGE: _____

Dear Patient, A few minutes of your time carefully answering the following questions will help the urologist in assessing your problems and giving you better care. Also, please complete the second page of this form.

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

Please check if you have a urologic history of the following:

Kidney disease _____ Kidney stones _____ Bladder trouble _____ Cancer of the urinary tract _____

Prostate cancer _____ Blood in the urine _____ Urine infection _____ Prostate trouble _____

Have you ever had any problem with or been treated for:

High blood pressure _____ Heart trouble _____ Stroke _____ Tuberculosis _____

Stomach ulcers _____ Diabetes _____ Other: _____

List all of the operations or surgeries you have had:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Have any members of your family had: Prostate cancer _____ Kidney stones _____ Kidney disease _____

Are you ALLERGIC to any medication? No _____ Yes _____ please list below:

1) _____ 2) _____ 3) _____ 4) _____

List the NAMES (and DOSE if known) of all the medication(s) you take everyday including herbs, and dietary supplements:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

Do you take aspirin everyday? No _____ Yes _____ Dosage _____

Are you: Single _____ Married _____ Widowed _____ Separated/Divorced _____

Do you smoke cigarettes? Yes _____ No _____ Quit _____ (How much? _____)

Do you drink alcohol? Yes _____ No _____ Quit _____ (How much? _____)

Do you drink caffeine? Yes _____ No _____ (How much? _____)

What is your occupation? _____

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Have you had any problem within the past six months with the following?
(CIRCLE IF YES)

GENERAL

Weight change
Chills
Fever

HEAD

Headaches
Recent head injury

EYES

Visual Changes
Double Vision
Glaucoma

EARS/NOSE/MOUTH/THROAT

Hearing loss
Recurrent nose bleeds
Hoarseness

RESPIRATORY

Shortness of breath
Frequent cough
Wheezing

CARDIAC

Chest pain
Palpitations
Heart Valve Disease

GASTROINTESTINAL

Abdominal pain
Frequent nausea/vomiting
Frequent diarrhea
Frequent constipation
Black stools
Blood in stools

MUSCULOSKELETAL

Joint pain
Joint swelling
Weakness
Back pain
Leg/Ankle swelling

NEUROLOGICAL

Dizziness
Seizures
Weakness in arms or legs
Numbness in arms or legs

SKIN

Chronic rash
Nonhealing lesions

PSYCHIATRIC

Nervousness
Depression
Mood changes

ENDOCRINE

Thyroid trouble
Diabetes
Excessive thirst

HEMATOLOGIC/LYMPHATIC

Anemia
Easy bruising/bleeding
Swollen lymph nodes

ALLERGIC/IMMUNOLOGIC

Hay fever
Environmental allergies