Urology Health History Questionnaire:

FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe)_____

Special Communication Needs:			
Language preference:			If 'yes' to any of the questions below, how can we assist?
Visual impairment	☐ Yes	☐ No	
Hearing impairment	☐ Yes	☐ No	
Speech impairment	☐ Yes	☐ No	
Cognitive impairment	☐ Yes	☐ No	
Sensory impairment	☐ Yes	☐ No	

Personal Health History

Please check past(P) or current(C) problems or conditions

P☐ C☐ Anxiety	P☐ C☐ Bladder problems
P☐ C☐ Blood disorder	P☐ C☐ Heart condition
P☐ C☐ High blood pressure	P☐ C☐ Liver problems
P☐ C☐ Hepatitis	P☐ C☐ Neurological condition
P☐ C☐ Psychiatric condition	P☐ C☐ Depression
P☐ C☐ Thyroid disorder	P☐ C☐ Lung disorder
P☐ C☐ Diabetes	P☐ C☐ **Cancer**
P☐ C☐ Breast problems	Type: _____
P☐ C☐ Kidney problems	P☐ C☐ Sexually transmitted disease
P☐ C☐ Abnormal pap smears	P☐ C☐ Other:_____
P☐ C☐ Stomach problems	☐ No current medical conditions

Previous Surgical Procedures

Please check if you have had any of the following

Procedure	Year
☐ Breast surgery	
☐ Hysterectomy	
☐ Vascular surgery/stent	
☐ Spine surgery ☐ Neck ☐ Back	
☐ Heart surgery	
☐ Prostate surgery	
☐ Other: _____ _____ _____	

Urology Health History

Frequency of urination: Daytime_____ Nighttime _____

Strength of Stream: Normal: _____ Decreased: _____ Poor: _____

Blood in Urine:	☐ Yes	☐ No	Leakage of Urine:	☐ Yes	☐ No
Urinary Infections:	☐ Yes	☐ No	Interruption of Urinary Stream:	☐ Yes	☐ No
Kidney or Bladder Stones:	☐ Yes	☐ No	Split Stream:	☐ Yes	☐ No
Urgent Urination:	☐ Yes	☐ No	Burning/Discomfort with Urination:	☐ Yes	☐ No
Dribbling After Voiding:	☐ Yes	☐ No	Hesitancy in Initiating Stream:	☐ Yes	☐ No

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner **In a sexual relationship?** ☐ Yes ☐ No

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Occupation: **Concerns**: ☐ Stress ☐ Hazardous subst. ☐ Heavy lifting **Exercise:** ☐ No ☐ Yes: ____times/week

Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker: Packs/day, how many years_____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often_____

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often_____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current
Describe:_____

Family History

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Cancer: ☐ _____	
☐ Heart Disease < 65 years of age		(list types) ☐ _____	
☐ Hypertension		☐ _____	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations	Last Occurrence	Tests	Last Occurrence
Influenza vaccine ☐ Yes ☐ No		Mammogram ☐ Yes ☐ No	
Gardasil (HPV) vaccine rec'd ☐ Yes ☐ No		Pap smear/pelvic ☐ Yes ☐ No	
		Colonoscopy ☐ Yes ☐ No	
		Bone Density ☐ Yes ☐ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

ALLERGIES: Please list *any* allergies to medications, foods, or materials (including latex)

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: _____ **Phone**: _____ **Store #**: _____

Location Description: _____

Additional Providers:

Primary Care Provider
Name: _____
Phone: _____ Last Seen:_____

Other: _____
Name: _____
Phone: _____ Last Seen: _____

Patient/Guardian Signature: _____ Date: _____