San Fernando Valley Urological Associates

HEALTH QUESTIONNAIRE

Name:_______________________________________ Date:_____________________

Age:_________ Race:________ Gender: M F Marital status: M S W D

Chief complaint. What is the reason for you visit today?

____

____

____

OFFICE USE ONLY:	associated symptoms
location of problem	
	duration
onset date	
aggravating or relieving factors	
	interfere with normal functions
severity	

Medical History

heart disease	Yes	No	psychiatric disease	Yes	No
heart attack	Yes	No	neurologic disease	Yes	No
high blood pressure	Yes	No	fainting spells	Yes	No
stroke	Yes	No	seizures	Yes	No
asthma	Yes	No	cancer	Yes	No
bronchitis/emphysema	Yes	No	abnormal bleeding	Yes	No
breast disease	Yes	No	arthritis	Yes	No
liver disease	Yes	No	do you smoke	Yes	No
gastrointestinal disease	Yes	No	alcoholic drinks per week___________________		
kidney disease	Yes	No			
diabetes	Yes	No			

If YES to any of the above please explain:____

____

Do you have difficulty getting or keeping erections?	Yes	No
Do you have difficulty delaying ejaculation or orgasm?	Yes	No
If YES are you interested in treatment for this?	Yes	No

Surgical History

Please list all surgical procedures including minor ones: Date

____ ________________

____ ________________

____ ________________

Medication:

Please list all medication you are currently taking:

name dose name dose

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Allergies: (please list any allergies you have)

____

Family History:

prostate cancer_______	abnormal bleeding:____	liver disease:_________
bladder cancer________	heart disease_________	other cancer________________
kidney cancer_________	lung disease_________	___________________________

Anything else we should know about your health?

____

REVIEW OF SYSTEMS

Do you now orhave you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other______________________

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other______________________

Allergic/Immunolgoic

Hay Fever	Y	N
Drug Allergies	Y	N

Other______________________

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other______________________

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other______________________

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other______________________

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other______________________

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other_____________________________

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other_____________________________

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore Throat	Y	N
Sinus problems	Y	N

Other_____________________________

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other_____________________________

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other_____________________________

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N

Other_____________________________

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other_____________________________

Physician use only: (Comments/Notes)