Patient History Questionnaire for Adults

[Chief Complaint] What is the reason for your visit today? ____

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[HPI] If Applicable describe the: *location(*ex: chest, throat) *duration* (ex: for 3 days), *quality* (ex: moderate, minimal), *severity* (ex: excruciating), *modifying factors* (ex: after eating), *timing* (ex: intermittent, for 2-3 minutes), *context* (ex: when lifting, when ambulating), *associated signs and symptoms* (ex: with nausea, dizziness).

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[Co-Active Conditions] What other conditions are you being treated for and what is the status of those treatments and your medical response (Ex: My diabetes is controlled on Glimepiride with fasting blood sugar this morning of 82.): ___________

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Review of Systems: Check Y for Yes, N for No. If there is more than one choice and only one applies as yes, circle it.

	Y	N		Y	N
Constitutional	X	X	High cholesterol or triglycerides		
Fever, chills, sweats or weight loss			Leg pain while walking		
Decrease in level of activity, abilities			Murmur		
Nutritional Impairment			Varicose Veins		
EYES	X	X	**Respiratory**	X	X
Visual disturbances, floaters			Shortness of breath		
Double Vision			Trouble sleeping at night		
Tearing or discharge			Sleep apnea		
ENT	X	X	Emphysema		
Oral ulcerations			History of pneumonia		
Nasal drainage or chronic sinusitis			Asthma		
Allergic Rhinitis (runny nose)			Coughing up blood		
Pain in swallowing, difficulty swallowing			Bronchitis		
Cardiovascular	X	X	Chronic cough		
Chest pain with or without activity			Recurrent sore throat		
Heart attack			TB		
Abnormal heart beats			**Gastrointestinal**	X	X
Valve disease			Abdominal pain		
High Blood pressure			Nausea, vomiting		
Poor leg circulation or swelling			Heartburn		
Atrial Fibrillation			Gallstones or Gallbladder pain		
Mitral Valve prolapse			Hepatitis		

Diarrhea			Stroke		
Blood in stools (coffee ground)			Seizure		
Rectal bleeding			Paralysis		
Loss of appetite			Multiple Sclerosis		
Constipation			Endocrine		
Hemorrhoids			**Musculoskeletal**	X	X
Change in bowel habits			Lumbago (chronic low back pain)		
Ulcers			Neck pain		
Jaundice			Knee pain		
Genitourinary Female	X	X	Rotator cuff pain or injury		
Pregnancies Total Lives Births C/section Y/N	X	X	Sciatica		
Birth control Method_____________________	X	X	Disc pain or injury		
Problem getting pregnant			Chronic hip pain		
Last Menstrual period ____________________	X	X	Arthritis requiring medication		
Irregular Period			Asymmetry (difference in size opposite extremities)		
Genitourinary Male and Female	X	X	Atrophy (loss of muscle mass)		
Sexually Active			**Endocrine**	X	X
Pain or discomfort with Urination			Intolerance to heat or cold		
Blood in urine			Goiter		
Kidney Infections			Uneven hair distribution		
Abdominal/Pelvic Pain			Unusual amount of thirst		
Frequent urination (Times per day avg __________)			Unusual amounts of urination		
Bladder infections			Diabetes		
Urgency with urination			**Hematologic/Lymphatic**	X	X
Feeling of incomplete emptying of bladder			Free bleeder		
Difficulty beginning urination			Enlarged lymph nodes		
Urinate frequently after retiring (# of times______)			Bruising		
Dribbling			Anemia		
Urine leakage (circle: with coughing, sneezing, laugh or severe urgency)			**Allergy/Immunologic**	X	X
History of Kidney stones			Seasonal Allergies or Hay Fever		
Sexually transmitted disease____________________			Immunizations current		
Have you seen another Urologist? If so, who?			Autoimmune disease		
Genitourinary Male	X	X	Immunodeficiency		
History of Prostate Cancer			HIV/Aids infection		
Enlarged Prostate			**Integumentary**	X	X
Difficulty attaining erection			Rashes		
Difficulty maintaining erection			Indurations		
Problem with stream (Circle: weak, strong, fair)			Ulcerations		
Interrupted stream			Itching		
Neurologic	X	X	**Psychiatric**	X	X
Headaches			Depression		
Tremor			Delusions		
Dizziness			Anxiety		
Numbness			Emotional disturbances		
Tingling					
TIA					

Explain Yes Answers above.____

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[Past Medical History] What medications are you taking?

Medication	Dosage/Timing	Conditions for this medicine and/or response.

Food allergies:____

Medication allergies:____

Medical Conditions Not addressed above:____

Past Surgical History:

Operation	Year		

Family History:

Indicate Diagnosis of Cancer, High Blood Pressure, Kidney Problems, Heart Attack, Diabetes, Stroke, all pertinent diseases.

Family Member	Diagnosis or Condition	Outcome/deceased/living

[Social History]: Are there any major changes recently in your life?____

Do you exercise?			How often?			What activity?					
Do you smoke?			How much?			Years?			Years since if quit:		
Consume Alcohol?			How much?			Alcohol problem			Treatment?		
Consume drugs?			Marijuana			Cocaine			Narcotics		

Are you Married/Widowed/Divorced/Separated/Single? Please circle.

How many children do you have living?____

Do you live alone or with others?____

Do you have a religious custom that you would like to discuss in relation to your illness?_______________________

Other relevant comments:____

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What is your occupation? ____