# UROLOGY ASSOCIATES OF SAN LUIS OBISPO

A Medical Group, Inc.

## HEALTH QUESTIONAIRE I

Your answers to the following questions will help your doctor become acquainted wtih your health history and health related matters. PLEASE PRINT CAREFULLY.

DATE ____________ YOUR FULL NAME______________________________ AGE _________

### PAST MEDICAL HISTORY

check the illnesses below that you have had or may have had. Check all answers YES or NO unless you do not know, than leave blank and discuss with the doctor.

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Glaucoma | ___ | ___ | Kidney disease | ___ | ___ |
| Lung disease, Asthma | ___ | ___ | Kidney Stones | ___ | ___ |
| Cancer | ___ | ___ | Kidney infection | ___ | ___ |
| Heart disease | ___ | ___ | Bladder infection | ___ | ___ |
| Heart murmur | ___ | ___ | Blood in Urine | ___ | ___ |
| Rheumatic fever | ___ | ___ | Venereal disease | ___ | ___ |
| High blood pressure | ___ | ___ | Diabetes | ___ | ___ |
| Heart attack | ___ | ___ | Gout | ___ | ___ |
| Abnormal heart rhythm | ___ | ___ | Nervous or mental disorder | ___ | ___ |
| Ulcer | ___ | ___ | Blood disease or clot | ___ | ___ |
| Liver disease or hepatitis | ___ | ___ | Stroke or seizure | ___ | ___ |

Have you seen a physician in the last year for a problem not mentioned above?______

If yes, for what?_______________________________________________________

List any surgery you have had:

| DATE | TYPE OF OPERATION |
|---|---|
| | |
| | |
| | |
| | |

List any other hospitalizations you have had:

| DATE | REASON FOR HOSPITALIZATION |
|---|---|
| | |
| | |
| | |
| | |

List any MEDICATION you are now taking and how often:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

List any MEDICATION you are ALLERGIC to:

_______________________________________________________________

_______________________________________________________________

OVER PLEASE

## SOCIAL HISTORY

Occupation: ______________________________ Level of education: ____________________

Marital Status: S M W D Year married _____ Prior marriage? ______ Children? ____________

Do you use tobacco now? ______ How much? ________________ For how long? ________

Have you ever smoked? ______ How much? ________________ When stopped? _______

Do you drink alcohol? ______ Type ____________________ Weekly amount ____________

Type ____________________ Weekly amount ____________

Do you exercise regularly? _________ What kind of exercise? ____________________________

What is your usual weight? ________

## FAMILY HISTORY

To the best of your knowledge, have any of your blood relatives (grandparents, parents, aunts, uncles, brothers, sisters, or children) had any of the following conditions? CHECK EACH ANSWER YES OR NO.

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| High blood pressure | ___ | ___ | Kidney disease | ___ | ___ |
| Cancer | ___ | ___ | Kidney stones | ___ | ___ |
| Diabetes | ___ | ___ | Anemia | ___ | ___ |
| Tuberculosis | ___ | ___ | Bleeding disorder | ___ | ___ |

## REVIEW OF SYSTEMS

Please answer the following regarding symptoms you are experiencing, or may have experienced in the past few years. CHECK EACH ANSWER YES OR NO.

| Do you have: | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| trouble with your vision? | ___ | ___ | joint pain or bone pain? | ___ | ___ |
| trouble hearing? | ___ | ___ | back problems? | ___ | ___ |
| difficulty swallowing? | ___ | ___ | severe depression or anxiety? | ___ | ___ |
| persistent cough? | ___ | ___ | excessive stress at home/work? | ___ | ___ |
| wheezing or shortness of breath? | ___ | ___ | blackouts or fainting spells? | ___ | ___ |
| chest pain, pressure or tightness? | ___ | ___ | numbness or weakness in arms/legs? | ___ | ___ |
| fast or irregular heart rate? | ___ | ___ | skin problems? | ___ | ___ |
| swelling in your feet or ankles? | ___ | ___ | easy bruising or excessive bleeding? | ___ | ___ |
| loss of appetite or weight loss? | ___ | ___ | problems with sexual function? | ___ | ___ |
| persistent nausea or vomiting? | ___ | ___ | hot flashes or night sweats? | ___ | ___ |
| chronic constipation or diarrhea? | ___ | ___ | leakage of urine? | ___ | ___ |
| blood in your stool? | ___ | ___ | difficulty urinating? | ___ | ___ |

FOR WOMEN:

Now many pregnancies have you had? _____

How many children have you had? _____

How many miscarriages? _____

Date of last menstrual period ___________

Date of last Pap test ___________

Please use the space below to mention any other things that you feel it would be helpful for the doctor to know:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________ Physician Signature

____________________ Date