Bellingham Urology Group PLLC

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ **Date of Birth**_____ **Today's Date**_____

Referring Physician_____ **Primary Care Doctor**_____

Reason for today's visit_____

When did this start?_____

MEDICAL HISTORY

Please check if you have ever had any of the following conditions:

- ❑ Diabetes
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Hepatitis
- ❑ Kidney Stones
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Gout
- ❑ Stroke
- ❑ Seizures
- ❑ Cancer, type:_____
- ❑ Lung problems:_____
- ❑ Eye problems:_____
- ❑ Heart problems:_____
- ❑ Other:_____

Please list any surgeries you have had and their approximate date/year:

_____

_____

_____

Please list any medication allergies and reactions:

_____

_____

Please list <u>all</u> medications, including vitamins and aspirin, you are currently taking. Please note dosage if possible.

_____

_____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

_____

_____

Please check if you have any FAMILY HISTORY:

- ❑ PROSTATE CANCER
- ❑ KIDNEY STONES
- ❑ OTHER CANCER:_____

PERSONAL HISTORY

Marital Status_____ **Do you live with anyone?**_____

Occupation_____

Do you currently smoke?_____ **Number of cigarettes per day?**_____ **For how many years?**_____

Did you quit smoking?_____ **When?**_____ **How long did you smoke?**_____ **Amount per day?**_____

Do you drink alcohol?_____ **Do you use other drugs?**_____ **If so, what?**_____

CONTINUE ON BACK

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PATIENT HEALTH QUESTIONNAIRE

Current Height:_____ Current Weight:_____

Do you now have, or have had, any <u>recent problems</u> related to the following systems? Please circle YES or NO.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Unexplained weight change	Y	N
Other _____		

Allergic/Immunologic

Drug allergies	Y	N
Other _____		

Eyes

Acute vision change	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other _____		

Neurological

Weakness	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
High blood pressure	Y	N
Known Heart problems	Y	N
Other _____		

Respiratory

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

Psychiatric

Depression	Y	N
Other_____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Constipation	Y	N
Fecal incontinence (leakage)	Y	N
Other_____		

Musculoskeletal

Neck pain	Y	N
Back pain	Y	N
Other _____		

Integumentary

Skin rash	Y	N
Genital Lesion	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Tired or sluggish	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

I have read through the full form and answered "YES" to any applicable symptoms. All unmarked symptoms are "NO."

Patient signature_____