CENTER FOR UROLOGIC CARE

OF BERKS COUNTY, PC

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
PLEASE PRINT IN BLACK OR BLUE INK.

Name (Last, First, M.I.) ☐ M ☐ F		**Date of Birth:**
Social Security#:	**Home Phone:**	**Cell Phone:**
Email:	**Height:**	**Weight:**
Referring Physician:	**Family Physician:**	
Primary Care Doctor:	**Emergency Name/Contact:(Can we contact them) YES ☐NO☐**	
Pharmacy Name:	**Pharmacy Location:**	

ALLERGIES

Are you allergic to Latex? YES ☐ NO ☐ **Are you allergic to IV/Contrast Dye? YES ☐ NO ☐**

Name the drug, food or product:	**Reaction You Had: (example; hives, rash, shortness of breath, etc.)**

MEDICATION

List or attach your medication and over-the-counter drugs, such as vitamins, supplements, and inhalers.
Do you take blood thinners? YES ☐ NO ☐ **☐ Check here if attaching a medication list**
Do you take Aspirin daily? YES ☐ NO ☐

Name the Drug	Strength	Frequency Taken

SURGICAL HISTORY

Please list all MAJOR surgeries, approximate date of procedure and what hospital.

Date	Surgery	Hospital

OTHER RECENT HOSPITALIZATIONS

Date	Reason	Hospital

MEDICAL HISTORY

Please answer the following questions.

UROLOGY SPECIFIC

Any blood in your urine?	**YES** ☐ **NO** ☐	Do you feel pain or burning with urination?	**YES** ☐ **NO** ☐
Back Pain?	**YES** ☐ **NO** ☐	Frequent urination?	**YES** ☐ **NO** ☐
Any problems with urination?	**YES** ☐ **NO** ☐	Sexually transmitted disease?	**YES** ☐ **NO** ☐
Do you have a hernia? Type of hernia:	**YES** ☐ **NO** ☐	Do you have problems emptying your bladder completely?	**YES** ☐ **NO** ☐
Do you usually get up to urinate during the night?	**YES** ☐ **NO** ☐	Any urinary tract, bladder or kidney infections?	**YES** ☐ **NO** ☐
WOMEN ONLY		**MEN ONLY**	
Are you pregnant or breast feeding?	**YES** ☐ **NO** ☐	Do you feel burning discharge from penis?	**YES** ☐ **NO** ☐
Have you had a D&C, hysterectomy, or Cesearean? (Circle all that apply)	**YES** ☐ **NO** ☐	Any difficulty with erection or ejaculation?	**YES** ☐ **NO** ☐
Any sexual or menstrual dysfunction?	**YES** ☐ **NO** ☐	Any testicle pain or swelling?	**YES** ☐ **NO** ☐
Date of last menstruation?		Date of last prostate and rectal exam?	

GENERAL MEDICAL HISTORY

COPD	YES ☐ NO ☐	Asthma	YES ☐ NO ☐
Emphysema	YES ☐ NO ☐	Shortness of Breath	YES ☐ NO ☐
Tuberculosis	YES ☐ NO ☐	Headaches or Migraines	YES ☐ NO ☐
Hard of Hearing	YES ☐ NO ☐	Bleeding Tendencies (not due to medication)	YES ☐ NO ☐
Thyroid Disease	YES ☐ NO ☐	Crohn's Disease	YES ☐ NO ☐
Diabetes Type:	YES ☐ NO ☐	Hepatitis Type:	YES ☐ NO ☐
Weight Loss	YES ☐ NO ☐	Weight Gain	YES ☐ NO ☐
Blood in Bowels	YES ☐ NO ☐	Antibiotics for Dental Work	YES ☐ NO ☐
High Blood Pressure	YES ☐ NO ☐	Glaucoma	YES ☐ NO ☐
Colonoscopy in the last 9 years? When:	YES ☐ NO ☐	Are you currently being treated for high blood pressure	YES ☐ NO ☐
Have you had the Pneumonia Vaccine?	YES ☐ NO ☐	Do you have an AICD	YES ☐ NO ☐
Atrial Fibrillation	YES ☐ NO ☐	Heart Attack	YES ☐ NO ☐
Cardiac Stent	YES ☐ NO ☐	Heart Murmur	YES ☐ NO ☐
Chest Pain	YES ☐ NO ☐	Coronary Artery Disease	YES ☐ NO ☐
Pacemaker	YES ☐ NO ☐	Artificial Heart Valve	YES ☐ NO ☐
Stroke	YES ☐ NO ☐	Blood Clots	YES ☐ NO ☐
Seizure	YES ☐ NO ☐	Anemia	YES ☐ NO ☐

FAMILY HISTORY

Please list any conditions that run in your family.

Prostate Cancer	YES ☐ NO ☐	☐ Father ☐ Brother ☐ Grandfather ☐ Uncle ☐ Son
Bladder Cancer	YES ☐ NO ☐	Who:
Kidney Stones	YES ☐ NO ☐	Who:
Kidney Disease	YES ☐ NO ☐	Who:
Diabetes	YES ☐ NO ☐	Who:
Cancer	YES ☐ NO ☐	Type(s):

Please list any other family conditions.

SOCIAL HISTORY

Please answer the following questions to the best of your ability.

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker

If a smoker, how long have you been a smoker? How many packs a day?

Do you drink alcohol? YES ☐ NO ☐ How many drinks per day:_____
Per week:_____ Per month: _____

How many caffeinated drinks do you drink in a day? What language do you speak?

What race are you considered?

Have you had a blood transfusion? YES ☐ NO ☐

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Rather not answer

Occupation:

Please list below any other information pertinent to your care:

PEOPLE WE CAN DISCUSS YOUR MEDICAL RECORD WITH:

☐ **DO NOT DISCUSS MY MEDICAL RECORD WITH ANYONE**

Name	Relationship

Patient/Responsible Party's Signature (required)

PRINT
NAME_____DATE:_____

X_____
SIGNATURE/The above is true and correct to the best of my belief.