



THE AUSTIN DIAGNOSTIC CLINIC
Department of Urology
Medical Questionnaire

Dear Patient:

Please take a few minutes to complete this form. This will help assure you of the best possible care and will be held in confidence as part of your medical record. Information contained here will not be released to anyone without your authorization to do so.

NAME: _____ Today's Date: _____
Last First M.I.

Age: _____ Date of Birth: ____/____/____ Occupation: _____
M D Y

Chief Complaint: _____ Consulting M.D.: _____

Please tell us why you chose to come here for your medical care (check all appropriate answers):

[] My personal physician recommended I come. [] My urologist recommended I come. If so, who _____

[] A family member, acquaintance, or someone who was a patient recommended I come. If so, who _____

[] I heard about Austin Diagnostic Clinic Urology through a newspaper, magazine, bulletin, TV, or radio.

[] I came on my own to see Dr. _____ because I had heard about him/her.

| | Still Yes | Alive No | Age now or at time of death | Cause of death | Have they had any major illnesses? Please indicate for each relative |
|---------|--------------|-------------|--------------------------------|----------------|---|
| Mother | | | | | |
| Father | | | | | |
| Brother | | | | | |
| Brother | | | | | |
| Sister | | | | | |
| Sister | | | | | |

| Please list current and past medical illnesses | Year | Please list prior hospitalizations | Year |
|--|------|------------------------------------|------|
| | | | |
| | | | |
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| | | | |
| | | | |

| Please list surgical procedures you have had | Year | Please list all medications you are taking (Include non-prescription drugs) |
|--|------|--|
| | | |
| | | |
| | | |
| | | |
| | | |

| Please list any medication allergies | Type of reaction | Do you smoke now or in the past? No _____ Yes _____ |
|--------------------------------------|------------------|--|
| | | Packs per day? _____ Years smoked _____ |
| | | If you have quit, please indicate year _____ |
| | | What is your daily caffeine intake (coffee, sodas, tea)? _____ |
| Please list your pregnancy history | Type of delivery | Do you use recreational drugs? No _____ Yes _____ |
| | | Do you use alcohol? No _____ Yes _____ |
| | | If yes, what is the amount? _____ |
| | | What is your marital status? |

REVIEW OF SYSTEMS

Do you now or have you had problems with any of the following?

| | Y | N | Please explain any Yes answers. |
|---|---|---|---------------------------------|
| GENERAL: Recent weight changes, fever, weakness, fatigue, headaches | | | |
| INTEGUMENTARY: Rashes, eruptions, dryness, jaundice, changes in skin, hair or nails, discoloration of skin | | | |
| EYES: Blurred vision, double vision, back pain | | | |
| EARS, NOSE, MOUTH & THROAT: Soreness and/or redness of gums, hoarseness, difficulty in swallowing, head colds, discharges, obstruction, postnasal drip, sinus pain, earaches | | | |
| MUSCULOSKELETAL: Joint pain, neck pain, back pain | | | |
| RESPIRATORY: Chest pain, wheezing, cough, difficulty breathing, asthma, bronchitis, pneumonia, tuberculosis, shortness of breath, emphysema | | | |
| NEUROLOGIC: Fainting, blackouts, seizures, paralysis, tingling, tremors, memory loss, dizzy spells, stroke | | | |
| CARDIOVASCULAR: Chest pain, rheumatic fever, rapid heart beat, high blood pressure, swelling, dizziness, faintness, varicose veins, heart valve problems | | | |
| ENDOCRINE: Thyroid trouble, fatigue, heat or cold intolerance, excessive sweating, thirst, hunger | | | |
| GASTROINTESTINAL: Appetite, nausea, vomiting, diarrhea, constipation, indigestion, food intolerance, hemorrhoids, jaundice, heartburn, diabetes, hepatitis | | | |
| GENITOURINARY: Male – Hernias, testicular problems, penile problems, impotency, infertility Female – Discharge, pain, discomfort Urinary – Frequent or painful urination, blood in urine, urinary infections, urine retention | | | |
| HEMATOLOGIC/LYMPHATIC: Anemia, easy bruising or bleeding, past transfusions, swollen glands, blood clotting problems | | | |
| PSYCHOLOGIC: Nervousness, mood swings, insomnia, headache, nightmares, depression | | | |
| ALLERGY/IMMUNOLOGIC: Food allergies, plant allergies, environmental allergies | | | |
| OTHER: AIDS, HIV | | | |

Physician use only: (Comments/Notes)

I have reviewed the *Medical Questionnaire* with the patient.

Faculty Signature

Date

PATIENT NAME _____ ● NPV ● ROV DATE _____