WEST ALABAMA UROLOGY ASSOCIATES

Office staff use only:
Vital Signs Height: Weight: BP:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.
Please complete all sections so we may have an accurate record of your medical history.

Name *(Last, First, M.I.):* ☐ M ☐ F	DOB:
Referring doctor/provider:	Primary care doctor/provider:

Reason for visit:

Pharmacy:	Allergies: (please list or attach) ☐ No allergies	
Address:	1.	3.
Phone number:	2.	4.

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (or attach list) ☐ None

Name the Drug	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Please circle (or list at bottom) any medical problems that other doctors have diagnosed ☐ None

Anemia	Anxiety	Arthritis	Asthma	Bleeding disorder	Blood clots
Breathing problems	Colorectal cancer	Depression	Diabetes	Gastrointestinal problems	GERD
Gynecologic problems	Heart attack	HIV	High blood pressure	Kidney disease	Liver disease
Migraines	Sexually transmitted disease	Stroke/seizure	Testicular problems	Thyroid problems	

Other (please list):

Surgeries – please list any surgical procedures ☐ None

Year	Procedure	Hospital (if known)

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
Tobacco	Do you use tobacco?	☐ Yes	☐ No	☐ # of years	☐ Or year quit _____
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
Drug use	Have you currently or recently used any drugs: ☐ Yes ☐ No Please circle any that apply:		marijuana cocaine amphetamines others		
Additional information	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No

WOMEN'S HEALTH HISTORY

Age at onset of menstruation:			
Date of last menstruation:			
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Number of pregnancies _____ Vaginal _____ Cesarean_____ Miscarriages_____			
Have you had a hysterectomy?		☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE (CURRENT/AT DEATH)	SIGNIFICANT HEALTH PROBLEMS (OR CAUSE OF DEATH)		AGE (CURRENT/AT DEATH)	SIGNIFICANT HEALTH PROBLEMS (OR CAUSE OF DEATH)
Father			**Grandmother** *Maternal*		
Mother			**Grandfather** *Maternal*		
Brother			**Grandmother** *Paternal*		
Sister			**Grandfather** *Paternal*		

REVIEW OF SYSTEMS

Please circle if you currently have any symptoms in the following areas:

	HEENT: Change in vision Dry mouth Other :
	Lung: Shortness of breath Cough Other:
GI: Abdominal pain Nausea Vomiting Other:	MSK: Back pain Muscle weakness Other:
Neurologic: Headache Numbness or weakness Other:	Psychiatric: Anxiety Other:
Hematologic: Easy bleeding Other:	Other symptoms (list):

Urinary: Painful urination Urinary frequency Urinary urgency Urinary incontinence Blood in urine Difficulty voiding Decreased urine output Pelvic pain Vaginal bleeding Vaginal discharge Genital lesion Genital itching Vaginal dryness Vagina odor Pain during intercourse Change in libido Other: