

San Fernando Valley Urological Associates
HEALTH QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Race: _____ Gender: M F Marital status: M S W D

Chief complaint. What is the reason for you visit today?

OFFICE USE ONLY: location of problem onset date aggravating or relieving factors severity	associated symptoms duration interfere with normal functions
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Medical History

heart disease	Yes	No	psychiatric disease	Yes	No
heart attack	Yes	No	neurologic disease	Yes	No
high blood pressure	Yes	No	fainting spells	Yes	No
stroke	Yes	No	seizures	Yes	No
asthma	Yes	No	cancer	Yes	No
bronchitis/emphysema	Yes	No	abnormal bleeding	Yes	No
breast disease	Yes	No	arthritis	Yes	No
liver disease	Yes	No	do you smoke	Yes	No
gastrointestinal disease	Yes	No	alcoholic drinks per week _____		
kidney disease	Yes	No			
diabetes	Yes	No			

If YES to any of the above please explain: _____

Do you have difficulty getting or keeping erections?	Yes	No
Do you have difficulty delaying ejaculation or orgasm?	Yes	No
If YES are you interested in treatment for this?	Yes	No

Surgical History

Please list all surgical procedures including minor ones: _____ Date _____

Medication:

Please list all medication you are currently taking:

name	dose	name	dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: (please list any allergies you have)

Family History:

prostate cancer _____	abnormal bleeding: _____	liver disease: _____
bladder cancer _____	heart disease _____	other cancer _____
kidney cancer _____	lung disease _____	_____

Anything else we should know about your health?

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Neurological

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

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

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

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

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

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _____		

Physician use only: (Comments/Notes)