New Patient Questionnaire

arizona institute of urology

BP: _____
Pulse: _____
Temp: _____
Weight: _____
Height: _____
Pain: _____
Fatigue: _____

Patient's Name: _____ Gender: M F
Spouse's Name: _____ Email:_____
Today's Date: _____ Date of Birth: _____ Age: _____
Ethnicity:_____ Race:_____ Preferred Language:_____
Reason for Today's Visit: _____
Primary Care Physician: _____ Urologist: _____
Advance Health Care Directives? (Living Will, Power of Attorney) Yes__ No__
Copy Filed with (name)_____Phone_____

Medical History: Have you ever had any of these diagnoses (Circle Y or N):

Previous cancer?	Y	N	Horseshoe kidney?	Y	N
High blood pressure?	Y	N	Thyroid disease?	Y	N
Heart disease?	Y	N	Lupus or Scleroderma?	Y	N
Pacemaker?	Y	N	Inflammatory bowel disease?	Y	N
Diabetes?	Y	N	Diverticulitis?	Y	N
Emphysema or COPD?	Y	N	Hemorroids?	Y	N
Kidney loss/dysfunction?	Y	N	Enlarged Prostate?	Y	N

Previous radiation therapy? Y N If so, to what part of the body? _____
At what facility? _____ Dates? _____
Previous or current chemotherapy? Y N If yes, what facility?_____Dates?_____

Have you ever been screened for colorectal cancer? Y N
Type of test? (please circle) **Fecal occult blood test** **Flexible sigmoidoscopy** **Colonoscopy**
Location and date of colorectal exam? _____

Previous Surgeries:

Type of Operation	Approximate Date	Type of Operation	Approximate Date
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Other illnesses and hospitalizations: _____

Family History:

Father: Type of Cancer? _____ Age Diagnosed _____ (Circle) Living/Deceased Age: _____
Mother: Type of Cancer? _____ Age Diagnosed _____ (Circle) Living/Deceased Age: _____
Sibling: Type of Cancer? _____ Age Diagnosed _____ (Circle) Living/Deceased Age: _____
Sibling: Type of Cancer? _____ Age Diagnosed _____ (Circle) Living/Deceased Age: _____
Other: _____
Other: _____

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Social History:

On average, how many caffeinated beverages such as coffee, soda, or tea do you have per day? _____

Do you drink alcohol? **Y** **N** If yes, average number of drink per day: _____

Do you have a personal history of alcoholism? **Y** **N** Do you have a personal history of recreational drug use? **Y** **N**

How many times in the past year have you had 5 or more drinks in a day? _____

Have you ever smoked cigarettes? **Y** **N** If yes, year began: _____ Year stopped: _____

Average packs per day: _____ List other tobacco products used: _____

How many times per week do you exercise? _____ Type of exercise:_____

Minutes per exercise session: _____

Current occupation: _____ # years: _____Previous occupation: _____ # years: _____

Are you a Vietnam Vet? **Y** **N**

Marital Status: _____ # of Children: _____

REVIEW OF SYSTEMS: (Check box to indicate YES)

Constitutional ☐ Fever ☐ Chills ☐ Weight Loss ☐ Fatigue ☐ Night Sweats Appetite (circle one) Good/Fair/Poor	**Gastrointestinal** ☐ Nausea/Vomiting ☐ Constipation/Diarrhea ☐ Blood in Stools ☐ Hemorrhoids ☐ Heartburn	**Genitourinary** ☐ Frequency/Urgency ☐ Painful Urination ☐ Urine Leakage ☐ Blood in Urine ☐ Nocturia ☐ Wear a Pad
Cardiovascular ☐ Heart Murmur ☐ Chest Pain ☐ Abnormal Heart Rate ☐ Fainting Spells ☐ Edema-Feet/Ankles	**Ears/Nose/Mouth/Throat** ☐ HOH/Hearing Aid ☐ Sinus Drainage ☐ Seasonal Allergies ☐ Nosebleeds ☐ Difficulty Swallowing	**Neurological** ☐ Dizziness ☐ Tremors ☐ Speech Difficulty ☐ Headaches
Respiratory ☐ Shortness of Breath ☐ Wheezing/Asthma ☐ Productive Cough	**Psychiatric** ☐ Anxiety ☐ Depression ☐ Memory Loss ☐ Confusion	**Eyes** ☐ Glasses/Contacts ☐ Double Vision ☐ Glaucoma ☐ Cataracts
Skin ☐ Rash/Psoriasis ☐ Open Wounds	**Musculoskeletal** ☐ Arthritis/Joint Pain ☐ Gout	**Endocrinological** ☐ Thyroid Problems
Hematological ☐ Anemia ☐ Excess Bruise/Bleed		