Coastal Carolina Urology Group LLC

John B. Adams, II, M.D. Louis F. Plzak, III, M.D. Michael C. Staley, M.D.

HEALTH QUESTIONNAIRE

The following information is very important to your health.
Please take time to fully and completely fill out this important information.

PATIENT NAME: ____ DATE: ___________________________

Date of Birth: _________________________ Height: ___________________ Weight: ____________________

RACE: Causasion African American Asian Other _________________________________ Decline

PREFERRED LANGUAGE: English Spanish Other ___________________________________ Decline

WHAT IS YOUR PRESENT PROBLEM THAT BRINGS YOU TO THIS OFFICE? ____

____

WHAT OTHER MEDICAL PROBLEMS DO YOU HAVE? ____

____

____

PLEASE LIST ANY PRIOR SURGERY: ____

____

____

DOES ANYONE IN YOUR FAMILY HAVE: ☐ PROSTATE CANCER ☐ KIDNEY CANCER ☐ KIDNEY STONES

☐ HEART DISEASE ☐ DIABETES

PLEASE LIST ANY MEDICATIONS YOU TAKE REGULARLY (INCLUDING DOSE):____

____

____

DO YOU TAKE ASPIRIN PRODUCTS? NO _____ YES _____ IF YES, HOW OFTEN? __________________

PLEASE LIST ANY DRUG ALLERGIES: ____

WHAT IS YOUR OCCUPATION? ____

DO YOU DRINK ALCOHOL? NO ___ YES ___ IF YES, HOW MUCH? ____

DO YOU SMOKE? NEVER _____ PREVIOUSLY ______, WHEN DID YOU QUIT? ________________________________

YES ____ CIGARETTES ____ CIGARS ____ SMOKELESS TOBACCO ____

HOW MUCH? ___________ FOR HOW LONG? ______________

PATIENT NAME: ______________________________________

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES	NO	
___	___	FREQUENT URINATION
___	___	CAN'T HOLD MY URINE (WET MYSELF)
___	___	PAIN OR BURNING ON URINATION
___	___	BLOOD IN URINE
___	___	AWAKEN AT NIGHT TO URINATE ____ TIMES
___	___	MY URINARY STREAM IS RESTRICTED
___	___	I MUST WAIT TO START URINATING
___	___	MY STREAM STOPS; AFTER WAITING I URINATE MORE
___	___	HISTORY OF PAST URINARY TRACT DISEASE
___	___	BACK PAIN
___	___	ABDOMINAL PAIN
___	___	GROWTHS
___	___	HERNIA
___	___	PROBLEMS WITH GENITALS
___	___	UNSATISFACTORY SEXUAL FUNCTION
___	___	PAST HISTORY OF SEXUALLY TRANSMITTED DISEASE

YES	NO	(ALL PATIENTS)
___	___	CHILLS, FEVER OR WEIGHT LOSS?
___	___	BLURRED VISION, PAIN IN EYES OR DOUBLE VISION?
___	___	FOOD OR SEASONAL ALLERGIES?
___	___	TREMORS, NUMBNESS OR TINGLING, CHRONIC DIZZY SPELLS?
___	___	CIRCULATION PROBLEMS?
___	___	CHRONIC HEADACHES?
___	___	EXCESSIVE THIRST, FEELINGS OF HOT OR COLD, TIRENESS?
___	___	HEARTBURN, DIARRHEA, CONSTIPATION?
___	___	BLOOD IN BOWEL MOVEMENTS
___	___	HIGH BLOOD PRESSURE, CHEST PAIN OR PRESSURE, EDEMA?
___	___	HEART TROUBLE, PALPITATIONS OR HEART ATTACK?
___	___	ACNE, MOLES, RASH?
___	___	ARTHRITIS, CRAMPS OR GOUT?
___	___	SORE THROAT, EAR INFECTIONS, SINUS PROBLEMS?
___	___	ASTHMA, SHORTNESS OF BREATH, CHRONIC COUGH?
___	___	ENLARGED GLANDS OR LUMPS
___	___	BLEEDER, BRUISE EASILY?
___	___	DEPRESSION, THOUGHTS OF SUICIDE?

FEMALE PATIENTS

☐ REGULAR PERIODS
☐ MENOPAUSE

DATE OF LAST PERIOD ___________

Patient's Signature

____
The above is true and correct to the best of my knowledge
.

1055 Ribaut Road, Suite 10, Beaufort, SC 29902 (843) 524-7607 FAX (843) 524-6737