Urological Clinic of Valdosta, PC
MEDICAL HISTORY QUESTIONNAIRE

DATE:_____ NAME:_____ AGE:_____

Referred by: □ SELF or _____

What is the reason for your visit today? □ Follow Up or □ New Problem (Please describe problem)

_____

_____

Medical Conditions

List any medical conditions that you have. (diabetes, asthma, hypertension, high cholesterol, history of cancer, any heart conditions, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medications

Do you take an ASPIRIN or BLOOD THINNER every day? □Yes □No

Do you take any medications daily? □Yes □No If yes, please list: (Include birth control, hormones, vitamins, and supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you had a flu shot this year? □Yes □No

Are you allergic to any medications or Latex? □ Yes □ No If yes, please list below.

Drug	**Reaction**	**Drug**	**Reaction**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Do you drink alcohol? □Yes □No How much? _____ How often? _____

Do you use any tobacco products? □Yes □No How much? _____ How many years? _____

If no, did you use any tobacco products in the past? □Yes □No Age quit: _____

Are you allergic to any foods? □ Yes □ No If yes, please list below.

_____ _____ _____

Surgical History

Please list all of the surgeries or operations you have had:

Date of surgery: **Type of surgery:**

_____ _____

_____ _____

_____ _____

_____ _____

Do you have a medical implant? □Yes □No If yes, please list: (pacemaker, cardioverter defibrillator)

_____ _____ _____

_____ _____ _____

Family History

Mother - □ Living □ Deceased Any medical problems? □Yes □ No If yes, please list: (Include kidney stones, diabetes, etc.)

_____

Father - □ Living □ Deceased Any medical problems? □Yes □ No If yes, please list: (Include kidney stones, diabetes, etc.)

_____

Have any of the men in your family had prostate cancer? □Yes □ No If yes, please list:

_____

Do you have any family members with a history of cancer? □Yes □ No If yes, please list:

Relationship: Type of Cancer:

_____ _____

_____ _____

_____ _____

Other important health history information

_____

_____