SPRING CREEK UROLOGY MEDICAL QUESTIONNAIRE

Your Name : _____
What is the main reason for your visit today? _____
Location of problem? _____
How severe is the problem (1 mild – 10 severe) : _____
When did you first notice the problem ? _____
How long does it last ? _____
Does any thing else occur at the same time ? _____
Does this interfere with your normal day? _____

UROLOGICAL MEDICAL HISTORY: Please select any Urology related problems you have

Erectile Dysfunction _____ Trouble urinating_____ Weak Stream_____
Curved penis/erection _____ Burning with urination_____ Urinary Urgency_____
Blood in urine_____ Urine leakage_____ Urinary frequency_____
Incomplete bladder emptying_____ Pain with Urination_____
Other:_____

PAST MEDICAL HISTORY: Please list any medical problems that you have been diagnosed with

SURGERIES:

YEAR	SURGERY

HOSPITALIZATIONS:

YEAR	REASON

ALLERGIES:

ALLERGY	REACTION

MEDICATIONS: Please list all current medications or attach a current medication list

Medication	Strength	Frequency

FAMILY HISTORY: Please list any significant family medical history

FATHER:
MOTHER:
SIBLING:
OTHER FAMILY MEMBERS:

SOCIAL HISTORY: All information contained in this questionnaire will remain strictly confidential.

MARITAL STATUS: Single Married Divorced Widow

 # OF CHILDREN: _____

OCCUPATION (if retired, previous occupation):
_____

ALCOHOL:
Do you drink alcohol? YES____ NO____ If yes, how often?_____

CAFFEINE: YES_____ NO_____ If yes, what kind and how often?_____

TOBACCO: (Please select the appropriate option)
Current Smoker YES_____ NO_____ If yes, type/how long/how much? _____
Former Smoker YES_____ NO_____ If yes, year quit? _____

DRUGS:
Do you currently use recreational or street drugs? YES_____ NO_____ If yes, what kind?_____