ASHEVILLE UROLOGICAL ASSOCIATES, INC.
PATIENT QUESTIONNAIRE

DATE______________ NAME____________________________________ AGE_______

Dear Patient,

A few minutes of your time carefully answering the following questions will help the urologist in assessing your problem and give you better care.

1. Was this consultation requested/arranged by a Physician? YES________NO________

2. If so, by whom?____

3. What is the main reason you are seeing the doctor today?________________________

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4. Have you seen a urologist before YES____ NO____ Who?______________________

5. Have you ever had a blood transfusion? YES_______________ NO_______________

6. Do you have any MAJOR MEDICAL problems (i.e. heart attack, asthma, diabetes, etc,)? YES____________________ NO___________________

7. Please list any MAJOR MEDICAL problems:
   1)_____________________ 2)_____________________ 3) _____________________

8. List all of the operations or surgery you have ever had:
   1)____________________ 2) ____________________ 3) _________________
   4) ____________________ 5) ____________________ 6) _________________

9. Do you take ASPIRIN everyday? YES__________________ NO________________

10. List the NAMES (and DOSE, if known) of any prescription or over the counter medicine you take.
    1) __________________ 2) __________________ 3) _________________
    4) __________________ 5) __________________ 6) _________________

11. Are you ALLERGIC to any medications? YES______________ NO______________

12. Please list any medications you are ALLERGIC to:
    1)__________________ 2) __________________ 3) _________________

(please continue on reverse side)

14. Occupation:____

15. Do you smoke? YES________ NO________ How much? ______________________

16. Do you drink alcohol? YES_______ NO_______ How much?____________________

17. Have any of the men in your family had Prostate Cancer? YES_________NO_________

18. Have you ever had any serious problem with or been treated for:

	YES	NO
CONSTITUTIONAL SYMPTOMS:		
Change in appetite		
Weight Change		
Chills		
Fever		
EYES:		
Glasses		
Cataracts		
ENT:		
Nose Bleed		
Difficulty Swallowing		
Hoarseness		
Hearing Loss		
RESPIRATORY:		
Shortness of Breath		
Cough		
Coughing up Blood		
CARDIAC:		
Chest Pain		
Heart Attack		
Palpitations		
High Blood Pressure		
GI:		
Abdominal Pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		
MUSCULOSKELETAL:		
Arthritis		
Joint Pain		
Joint Replacement		
Back Pain		

	YES	NO
NEUROLOGICAL:		
Dizziness		
Seizure		
Headache		
Loss of Conciousness		
SKIN:		
Rashes		
Non-Healing Lesions		
PSYCHIATRIC:		
Nervousness		
Mood Changes		
Depression		
ENDOCRINE:		
Thyroid Trouble		
Diabetes		
HEMATOLOGY:		
Anemia		
Easy Bruising		
Swollen Glands		
GENITO-URINARY:		
Kidney Disease		
Kidney Stones		
Bladder Trouble		
Blood in Urine		
Urinary Infection		
Prostate Gland		
Urinary Incont.		
Urinary Frequency		