Medical Record Number

Patient Name

Addressograph Stamp - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

UROLOGY CLINIC HEALTH SURVEY

The answers to these questions will help us to diagnose and treat your health problems. Please answer all of the questions to the best of your ability before your first visit so that we can focus on your urologic problem during the appointment. Print in ink or type if possible. Bring the form with you and save a copy for your records if you wish. Thank you.

Identification

Date Completed_____

Full Name_____ Date of Birth (Month, Date, Year) _____

Physicians

Primary–Internist/Family Physician

Name _____

Address _____

_____

City _____ State ____ Zip ____

Phone _____

Urologist/Other

Name _____

Address _____

_____

City _____ State ____ Zip ____

Phone _____

Who actually referred you to this clinic? _____

Past Medical History (Circle YES or NO for all illnesses that apply to YOU, now or in the past)

Asthma/Bronchitis/Emphysema	YES	NO	Kidney disease	YES	NO
Back Injury/Arthritis	YES	NO	Liver disease/Hepatitis	YES	NO
Cancer (type) _____	YES	NO	Neurologic disease	YES	NO
Diabetes	YES	NO	Psychiatric disease or depression	YES	NO
Heart attack/angina	YES	NO	Stroke	YES	NO
Heart valve or rhythm problem	YES	NO	Thyroid disease	YES	NO
High blood pressure	YES	NO	Ulcers	YES	NO
Immune disorder (type) _____	YES	NO	Vascular disease/blood clots	YES	NO

Other significant medical problems (please describe) _____

_____

Social History:

TOBACCO: Never smoked ____ Lifetime smoking—packs/day ____ Years smoked _____ Quit smoking in ____

ALCOHOL: Number of drinks in a typical week ____ Have you had a problem with alcohol or drug use? YES NO

MARITAL STATUS: _____

OCCUPATION: _____ – REGULAR EXERCISE (Yes/No) If yes, specify _____

Current medications: (Please be accurate, check your prescription if in doubt. List name of drug, dose and frequency of use. Include prescription and over the counter meds. Include medications taken "as needed" with frequency of use):

Allergies: (List any allergies to medication here)_____

Are you allergic to intravenous contrast, shellfish, or iodine? (Yes/No)

Surgical history (Please be as specific as possible)

OPERATION	MONTH/YEAR	REASON FOR SURGERY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other hospitalizations/serious illnesses/trauma (please list other serious problems and approximate dates)

Family History (please describe any significant medical problems that have occurred in your family, particularly any problems involving the urinary tract such as kidney stones, urologic or gynecologic cancers, urinary infections, etc.)

Gynecologic/Obstetric History (women only)

Menstrual history: Age at First Menses _____ Currently menstruating (Yes/No)

If yes, are periods regular (Yes/No) Spacing of periods _____ Duration of bleeding _____

If no, when did periods stop _____ Menopause or hysterectomy?

Obstetric history: Total pregnancies ___ Vaginal deliveries ___ C-sections ____ Abortions ____ Miscarriage ____

Complicated deliveries YES/NO If yes specify _____

Date of last PAP smear _____ Any abnormal PAP smears (YES/NO) Last mammogram _____

Current Review of Systems:

Have you had any problems in these areas in the past year? Circle YES or and explain YES answers

		PATIENT COMMENTS	PHYSICIAN COMMENTS
Allergic/Immunologic (rashes/infections/etc.)	Yes / No		
Constitutional (general health, weight, energy)	Yes / No		
Cardiovascular (heart/blood vessels/circulation)	Yes / No		
Eyes (any visual problems)	Yes / No		
Ears/Nose/Mouth/Throat (hearing/infections/congestion/pain)	Yes / No		
Endocrine (hormones/metabolism/thyroid)	Yes / No		
Gastrointestinal (stomach/intestines/bowel movements)	Yes / No		
Hematologic/Lymphatic (bleeding/lymph nodes/swollen glands)	Yes / No		
Musculoskeletal (bones/joints/muscles)	Yes / No		
Neurological (brain/nervous system)	Yes / No		
Psychiatric (emotions/mood/memory)	Yes / No		
Respiratory (lungs/breathing)	Yes / No		
Integumentary (skin lesions/breast lumps)	Yes / No		
Genitourinary (genitals/sexual function/kidneys/bladder)	Yes / No		

Form completed by: _____
please print

Relationship to patient: _____
write SELF if you are the patient

FOR OFFICE USE ONLY
PROVIDER DOCUMENTATION

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however the questionnaire may be referenced for additional details.

_____ _____

Attending Physician Signature date

The preceding information was also reviewed by:

_____ _____

Provider Signature date

_____ _____

Provider Signature date

_____ _____

Provider Signature date