

The Urology Group
Patient Questionnaire (Page 1 of 2)

OFFICE USE ONLY: REVIEWED BY: _____ DATE: _____ ENTERED/NURSE: _____
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Today's Date: _____

Name: _____ Date of Birth: _____

Occupation: _____

Primary Care Dr: _____ Did a Dr. Refer you here? Who? _____

*Please bring all RADIOLOGY FILMS with you at the time of your appointment.
You can pick up your FILMS at the radiology facility/hospital where you had them done.*

*The following information is **confidential** and will not be released to anyone without your authorization.*

Chief Complaint

What is the main reason you are seeing the doctor today? _____

Please fill in below, or if you have a list already made, you may give us that:

Allergies (please list all medication allergies and those to shellfish, etc.): None

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Medicines you CURRENTLY take: None

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

7) _____ 8) _____ 9) _____

Medical problems: None

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Surgeries, including heart valve or joint replacement: None

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

When was your last EKG? _____ Where? _____

When was your last chest x-ray? _____ Where? _____

FAMILY HISTORY

Have any members of your family had cancer or any other conditions the kidneys, bladder, prostate or testicles? Please specify:

If yes, family member(s) _____ condition _____

_____ condition _____

If no, please check here: My family has no history of any urologic cancers or conditions

