PRESTIGE MEDICAL GROUP

HEALTH QUESTIONNAIRE

Date:_____ Patient Name:_____ Date of Birth: _____

Current Medical Complaints:

			Male:			**Female**:		
Blood in Urine	☐Yes	☐No	Testicular lump/pain	☐Yes	☐No	Dropped Bladder	☐Yes	☐No
Kidney Stones	☐Yes	☐No	Prostate Infection	☐Yes	☐No	Pelvic Pain	☐Yes	☐No
Bladder Cancer	☐Yes	☐No	Enlarged Prostate	☐Yes	☐No	Vaginal Pain	☐Yes	☐No
Leakage of Urine	☐Yes	☐No	High PSA	☐Yes	☐No	Vaginal Dryness	☐Yes	☐No
Bladder Infection	☐Yes	☐No	Erectile Dysfunction	☐Yes	☐No	Painful Intercourse	☐Yes	☐No
Sexual Dysfunction	☐Yes	☐No	Prostate Cancer	☐Yes	☐No	Other: _____		
Bladder Pain	☐Yes	☐No	Testicular Cancer	☐Yes	☐No			
Overactive Bladder	☐Yes	☐No	Other: _____					
Kidney Cancer	☐Yes	☐No						

ALLERGY HISTORY: ☐ No Known Allergies

	Reaction		Reaction		Reaction
☐Penicillin		☐Cipro/Levaquin		☐Iodine/Contrast	
☐Keflex		☐Doxycycline		☐Latex	
☐Sulfa		☐Hydrocodone		☐Adhesive Tape	
☐Macrobid		☐NSAID		☐ Aspirin	

☐ Other: _____

MEDICATIONS: Please list all Medications & Supplements (include dosage & how often it is taken):

_____

_____

MEDICAL CONDITIONS/HISTORY:

☐ Diabetes ☐Hypertension ☐ Parkinson's ☐Multiple Sclerosis ☐Chronic Lower Back Pain ☐ Heart Failure
☐ Hx of Kidney Infection ☐ Hx of Heart Attack/Stroke ☐ IBS ☐ Heart Disease ☐ Endometriosis ☐ Dementia
☐ Hepatitis ☐ Cirrhosis ☐ Kidney Disease ☐ Thyroid Disease ☐ Auto Immune Disorder ☐ Sleep Apnea
☐Cancer: _____ ☐Other: _____

SURGICAL HISTORY:

	Year		Year		Year		Year
Cystoscopy		Gallbladder		Prostatecomy		Hysterectomy	
Lithotripsy		Colon		Prostate Resection		Urethral Sling	
Hernia		Kidney Stone		Vasectomy		Bladder Repair	
Appendectomy		Knee Surgery		Prostate Biopsy		Rectal Repair	
Hip Replacement		Lower Back		Orchiectomy		C-section	

☐Other: _____

FAMILY HISTORY:

Relative	Age	Health Problems	If deceased, cause
Father			
Mother			

Patient Signature:_____Date: _____

Brother/Sister			

PRESTIGE MEDICAL GROUP

HAS ANY BLOOD RELATIVE EVER HAD:

	Yes	No	Relation		Yes	No	Relation
Bladder Cancer				Uterine Cancer			
Kidney Cancer				Ovarian Cancer			
Prostate Cancer				Endometrial Cancer			
Testicular Cancer				Kidney Stones			
Other: _____							

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐ Life Partner
Occupation: _____

Alcohol consumption: ☐Yes ☐No ☐Former If yes, how often and how much? _____

Caffeine consumption: ☐Yes ☐No If yes, how many cups a day? _____

Tobacco use: ☐Never ☐Former User ☐ Current User
Cigarettes/day: _____ Years Used: _____ Year Quit: _____

If you are a Female: Are you still menstruating? ☐Yes ☐ No

Are you pregnant: ☐Yes ☐ No If no, do you use Birth Control or Hormone Replacement: ☐Yes ☐ No
Date of Last Menstrual Period: _____
Number of Pregnancies: _____ Number of Children: _____ Number of Miscarriages/Abortions: _____
Number of Vaginal deliveries: _____ Number of C-Sections:_____

REVIEW OF SYSTEMS: (check all that apply)

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Vision Loss
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Allergies	☐ Nasal Stuffiness
Cardiovascular	☐ Chest Pain	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory	☐ Shortness of Breath	☐ Wheezing	☐ Chronic Cough
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
	☐ Leakage of Stool	☐ Constipation	☐ Diarrhea
Genitourinary	☐ Incontinence	☐ Kidney Pain	☐ Pelvic Pain
	☐ Urgency/Frequency	☐ Testicular Pain	☐ Painful Intercourse
	☐ Incomplete emptying	☐ Prostate Infection	☐ Bladder Infection
	☐ Painful Urination	☐ Genital infection	☐ Vaginal Dryness
	☐ Nighttime Urination	☐ Blood in Urine	☐ Weak Stream
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic/Lymphatic	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Blood Clotting Issues
Psychiatric	☐ Anxiety	☐ Depression	☐ Insomnia
	☐ Memory Loss	☐ Bipolar	☐ PTSD

Patient Signature:_____Date: _____

☐ Other: _____

Patient Signature:_____Date: _____