Beth Israel Deaconess Medical Center
Boston, MA 02215

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

*Patient Identification*

# MEDICAL HISTORY QUESTIONNAIRE
# NEW OUTPATIENT
## Urology Division

MR2229

**Please read carefully and fill in**

Who is your primary care doctor? _____

Who sent you to us? _____

What is the reason for today's visit? _____

_____

| REVIEW OF SYSTEMS: | Do you have - or have you recently had - any of the following? | No | Yes |
|---|---|---|---|
| **Genitourinary** | Trouble starting to urinate | | |
| | Frequent urination | | |
| | Blood in urine | | |
| | Urinary tract infection | | |
| | Burning on urination | | |
| | Loss of urine (leaking) | | |
| | Sexually Transmitted Disease | | |
| **Constitutional** | Fever or Chills | | |
| | Weight loss or gain | | |
| **Eyes** | Glaucoma | | |
| **Ears / Nose / Throat** | Trouble swallowing | | |
| | Hearing Loss | | |
| | Vertigo (feeling dizzy) | | |
| **Nervous System** | Have you ever passed out or fainted? | | |
| | Numbness or tingling in your arms or legs | | |
| | Headaches | | |
| | Blurred vision | | |
| | Shakiness when walking | | |
| **Cardiovascular** | Chest pain | | |
| | Swelling in your ankles / feet | | |
| | Heart skipping / pounding | | |
| | Neck, jaw or arm pain that may be related to your heart | | |
| | Cramping or tightness in your legs when walking | | |
| **Respiratory** | Shortness of breath | | |
| | Wheezing | | |
| | Coughing up blood | | |
| **Gastrointestinal** | Constipation or diarrhea | | |
| | Nausea or vomiting | | |
| | Do you have a history of ulcers? | | |
| | Bleeding from your rectum or vomiting blood | | |
| **Musculoskeletal** | Joint aches, muscle aches or arthritis, back pain | | |
| **Skin** | Skin rashes | | |
| **Hematologic / Lymphatic** | Painful or swollen glands | | |
| | Do you bruise easily? | | |
| **Psychiatric** | Do you have a history of depression or other psychiatric illness? | | |

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| MEDICAL / SURGICAL HISTORY: | No | Yes | If Yes, explain here |
|---|---|---|---|
| Heart Disease / Angina / Chest Pain | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Heart Valve Disease / Heart Murmurs | | | |
| Heart Arrhythmias / Atrial Fibrillation | | | |
| Diabetes | | | |
| Poor Leg Circulation / Blood Clots | | | |
| Kidney Disease | | | |
| Stroke / TIA (Transient Ischemic Attack) / Mini-stroke | | | |
| Seizures / Epilepsy / Parkinson's / Multiple Sclerosis | | | |
| Asthma / Hay Fever | | | |
| Pneumonia / Bronchitis | | | |
| Emphysema | | | |
| HIV or AIDS | | | |
| Hepatitis / Liver Disease | | | |
| Thyroid Disease | | | |
| Anemia (Low Iron) / Blood Transfusions | | | |
| Stomach Ulcers / Acid Reflux | | | |
| Cancer (Type: ) | | | |
| Depression / Anxiety / Psychiatric Condition | | | |
| Surgeries | | | |
| Number of Pregnancies: _____ ☐ N/A | Number of Live births: _____ ☐ N/A | | |

**Please look at the medication sheet you received at "check-in."**
If you are taking any medications that are **NOT** listed on that sheet, please list them below. **Include:**
- prescription drugs
- inhalers
- aspirin products
- non-steroidal anti-inflammatories (such as ibuprofen)
- eye drops
- herbal supplements
- nutritional supplements
- over-the-counter medications and non-prescription drugs.
- vitamins

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List all allergies, sensitivities and medication reactions: Include:**
- medications
- vaccinations
- foods
- insects / venom, such as bee stings
- substances, such as latex
- environmental allergies
- reactions to anything else , including iodine or radiology contrast material.

☐ I have no known allergies, sensitivities or medication reactions.

| *Allergy / Sensitivity / Medication Reaction* | *Type of Reaction* |
|---|---|
| Medication: | |
| Contrast / Dye: | |
| Shellfish: | |
| Latex: | |
| Other: | |

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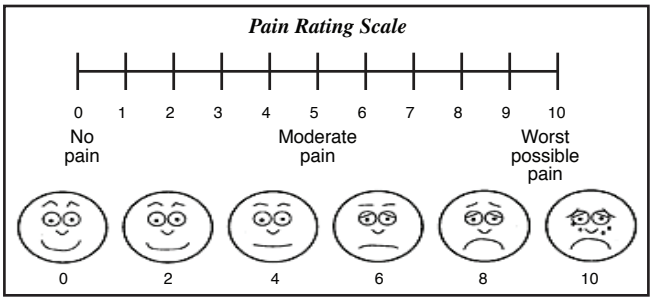
**PAIN Level** (How bad is the pain?)**:** ☐ 0 ☐ 2 ☐ 4 ☐ 6 ☐ 8 ☐ 10

Location (Where do you hurt?): _____




## SOCIAL HISTORY:

Are you: ☐ Single ☐ Divorced ☐ Married ☐ Widow / Widower

Who lives with you? _____

Are you working now? ☐ No ☐ Yes Occupation: _____ Employer: _____

Do you smoke? ☐ No ☐ Yes How many packs per day: ____ For how many years: ____

Did you smoke in the past? ☐ No ☐ Yes Year that you quit: _____

Do you drink alcohol? ☐ No ☐ Yes How much per day: ____ per week: ____ per month: ____

Do you use recreational drugs? ☐ No ☐ Yes What kind? _____

## FAMILY HISTORY:

| Has anyone in your immediate family had the following? | No | Yes |
|---|---|---|
| High blood pressure | | |
| Diabetes | | |
| Heart disease (heart attack, sudden death, heart failure) | | |
| Stroke | | |

**What is the health of your:**

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

**Patient Certification**: I have answered these questions the best of my ability. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to tell the doctor's office of any changes in my medical status.

X_____ _____ **OR**
Patient's Signature Print Name

X_____ _____ **and** _____
Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ___/___/___ Time: ___ ___ : ___ ___ ◯ a.m. ◯ p.m.

**Physician Review:** I have reviewed this information with the patient and/or the patient's representative.

X_____M.D. _____M.D. ____/____/____ ___ ___ ___ ___
Physician Signature Print Name Date Time (24 hour)