PATIENT HEALTH QUESTIONAIRE Washington University – Urologic Surgery

Name: DOB: Date of Visit:

Referring Physician:
Referring Physician's Address:

CONSTITUTIONAL			**MUSCULO-SKELETAL**		
weight loss	❑-yes ❑-no		Prolonged back pain	❑-yes ❑-no	
prolonged fevers	❑-yes ❑-no		Artificial (implanted) joints	❑-yes ❑-no	
CARDIOVASCULAR			**NEUROLOGIC**		
High blood pressure	❑-yes ❑-no		Strokes/"mini-stroke" (TIA)	❑-yes ❑-no	
Angina/chest pain/ Heart attack (MI)	❑-yes ❑-no		Parkinson's disease	❑-yes ❑-no	
Heart valve problem/ Irregular pulse (arrhythmia)	❑-yes ❑-no		Alzheimer's disease or confusion	❑-yes ❑-no	
RESPIRATORY			Multiple Sclerosis (MS)	❑-yes ❑-no	
Asthma	❑-yes ❑-no		Seizures (epilepsy)	❑-yes ❑-no	
Emphysema	❑-yes ❑-no		Spinal cord injury	❑-yes ❑-no	
Prolonged cough or shortness of breath	❑-yes ❑-no		**EYES**		
GASTROINTESTINAL			Glaucoma	❑-yes ❑-no	
Ulcers	❑-yes ❑-no		Vision changes	❑-yes ❑-no	
Hepatitis	❑-yes ❑-no		**PSYCHIATRIC**		
Constipation	❑-yes ❑-no		Anxiety	❑-yes ❑-no	
GENITO-URINARY			Depression	❑-yes ❑-no	
Bloody urine	❑-yes ❑-no		**IMMUNOLOGIC**		
Leak urine/poor urinary control	❑-yes ❑-no		Lupus	❑-yes ❑-no	
Poor erectile/sexual function	❑-yes ❑-no		AIDS / HIV	❑-yes ❑-no	
Stones	❑-yes ❑-no		**INTEGUMENTARY**		
ENDOCRINE			Rashes	❑-yes ❑-no	
Diabetes	❑-yes ❑-no		Boils or infections	❑-yes ❑-no	
Gout	❑-yes ❑-no		**Notes:**		
Thyroid abnormality	❑-yes ❑-no				
HEMATOLOGY					
Excessive bleeding with surgery	❑-yes ❑-no				
Anemia	❑-yes ❑-no				
Blood clots in legs/lungs	❑-yes ❑-no				

PLEASE ALSO COMPLETE THE REVERSE SIDE ➔➔➔➔

List any Hospitalizations or Surgeries- Include Month and Year

☐ **None**

List any Illnesses you have had – Include Month and Year: (High Blood Pressure, Diabetes, Etc.)

☐ **None**

Current Medications (including over-the-counter meds and supplements)**: Please list:**

☐ **None**

Preferred Pharmacy:
Name:_____ Phone #_____
Address:_____
City:_____ State_____ Zip:_____

Are you allergic to any medications/dye/contrast? If YES List.

☐ **None**

Other allergies please list: (seasonal, anesthesia etc)

☐ **None**

Social History: please check the appropriate answer.

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Alcohol Use: ☐Never ☐1-3 drinks/week ☐4-6 drinks/week ☐>6 drinks/week ☐ Quit, year_____

Tobacco Use: ☐Never ☐Current Every Day ☐Current Someday ☐ Former Smoker

Drug Use: ☐None ☐Yes type/frequency

Occupation:

Family History: Please write in any medical conditions family members have/had. If none check NONE

Family Member	Conditions(s)	NONE
Mother		☐
Father		☐
Sibling		☐
Children		☐

Female Patients ONLY:
Are you still having menstrual periods? ☐ YES ☐ NO Are they abnormal? ☐ Yes ☐ No

FOR DOCTOR USE ONLY ---- I have reviewed this questionnaire with the patient today:

Today's Date: **Physician's Signature:**

RD revised 1/06
VP 9/06/
KW 2/12
Kaw3.14