PATIENT HEALTH QUESTIONAIRE Washington University - Urology

| Name: | DOB: | Date of Visit: |
|---|---|---|
| Referring Physician: | | |

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

☐ **None**

**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 ☐ Daily, current packs/day_____ ☐ Quit, year_____ **No. of years smoked_____**

Drug Use: ☐ None ☐ Yes type/frequency_____

Occupation:

**Family History**: Please circle or list any diseases that run in your family.

| | | |
|---|---|---|
| Heart Disease<br>Stroke<br>Diabetes<br>Cancer | Urinary Stones<br>Kidney Disease<br>Prostate Cancer | Other specific disease: |

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:** **Signature:**

RD revised 1/06
VP 9/06