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PATIENT HEALTH QUESTIONNAIRE

Dear Patient,

In order to assess your healthcare needs and to better serve you, we ask that you answer all the questions below as accurately as possible:

TODAYS DATE: _____

NAME: _____ **DOB:** _____

FAMILY PHYSICIAN: _____ **PHARMACY:** _____

What is the purpose of your visit today? _____

SYMPTOMS: Please check if you have any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Frequency of Urination | <input type="checkbox"/> Decreased force or pressure of stream |
| <input type="checkbox"/> Bladder Pain | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Changes in bowel habits |
| <input type="checkbox"/> Dribbling after Urination | <input type="checkbox"/> Pain in the side |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Incomplete Bladder Emptying |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Blood in the Urine |
| <input type="checkbox"/> Previous Kidney Stones | <input type="checkbox"/> Strain to Empty Bladder |
| <input type="checkbox"/> Penis Pain or Discharge | <input type="checkbox"/> # of times you get up at night to urinate _____ |
| <input type="checkbox"/> Testicle pain or Swelling | <input type="checkbox"/> Incontinence (leakage of urine) |
| <input type="checkbox"/> Pain with Ejaculation | <input type="checkbox"/> Vaginal pain or Discharge |
| <input type="checkbox"/> Urgency with Urination | |

How long have these problems been bothering you? _____

Have you been treated for a sexually transmitted disease? ☐ **YES** ☐ **NO**

Do you have sexual concerns? ☐ **YES** ☐ **NO**

Do you have any erectile problems? ☐ **YES** ☐ **NO**

Are any of the above symptoms getting worse? ☐ **YES** ☐ **NO**

How would you rate your general health: ☐ **Excellent** ☐ **Very Good** ☐ **Good** ☐ **Fair** ☐ **Poor**

PAST HEALTH PROBLEMS: Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Glaucoma/ Eye Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Cholesterol Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's, M.S., Neurologic Disorders |
| | <input type="checkbox"/> Auto Immune Disease |

PLEASE LIST ALL OTHER PAST MEDICAL HEALTH PROBLEMS NOT LISTED ABOVE:

PREVIOUS SURGERY: (List approximate year of surgery)

Tonsils/Adenoids _____
Appendectomy _____
Joint Replacement _____
Breast _____
Gallbladder _____
Prostate _____
Bladder _____

Hysterectomy _____
Hernia _____
Cardiac Bypass _____
Cardiac Stent Placement _____
Vasectomy _____
Removal of Ovaries _____

PLEASE LIST ALL OTHER SURGERIES YOU HAVE HAD THAT ARE NOT LISTED ABOVE:

HAVE YOU HAD ANY PRIOR PROBLEMS WITH ANESTHESIA? ☐ YES ☐ NO
IF YES, WHAT HAPPENDED? _____

PLEASE LIST ANY ALLERGIES YOU HAVE TO PRESCRIPTION MEDICATION:

FOOD ALLERGIES: _____

OTHER SUBSTANCES (tape, latex, etc): _____

Can you eat strawberries, shellfish, or iodized salt? ☐ YES ☐ NO

SOCIAL HISTORY:

Are you married? ☐ YES ☐ NO

Widowed ☐ YES ☐ NO

Divorced ☐ YES ☐ NO

Do you live with a significant other?

☐ YES ☐ NO

of children _____

FEMALES:

of Pregnancies _____ # of live Births _____ # of Miscarriages _____

What is your occupation? _____ Job description: _____

Have you *ever* smoked cigarettes or used tobacco in any form? ☐ YES ☐ NO

Do you use E-cigarettes or Vape? ☐ YES ☐ NO

Do you currently? ☐ YES ☐ NO If so, how many packs a day? _____ For how many years? _____

Do you drink alcoholic beverages? ☐ YES ☐ NO If so, how many per week? _____

PATIENT NAME _____ DOB _____

FAMILY HISTORY: PLEASE LIST ANY FAMILY MEMBER WITH ANY OF THE DISORDERS LISTED BELOW:

Cancer/Tumor _____	Prostate Cancer _____
HIV/AIDS _____	Hepatitis _____
Anesthesia Problems _____	Asthma/Emphysema _____
Bleeding Problems _____	Bladder Cancer _____
High Blood Pressure _____	Tuberculosis _____
Kidney Cancer _____	Strokes _____
Heart Problems _____	Heart Attack _____
Diabetes _____	Thyroid Problem _____
Kidney Stones _____	

REVIEW OF SYSTEMS:

PLEASE CHECK ALL CURRENT PROBLEMS OR PAST HEALTH PROBLEMS:

Constitutional Symptoms

- ☐ Fever
- ☐ Chills
- ☐ Weight Loss/Gain

Eyes

- ☐ Double Vision
- ☐ Pain
- ☐ Blurred Vision

Ear/Nose/Throat/Mouth

- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Ear Infection

Respiratory

- ☐ Shortness of breath
- ☐ Frequent cough
- ☐ Wheezing

Gastrointestinal

- ☐ Indigestion/Heartburn
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain

Genitourinary

- ☐ Urinary Frequency
- ☐ Painful Urination
- ☐ Urine Retention

Musculoskeletal

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain

Integumentary

- ☐ Boils
- ☐ Persistent Itching
- ☐ Skin Rash

Neurological

- ☐ Numbness/Tingling
- ☐ Dizzy spells
- ☐ Tremors

Endocrine

- ☐ Tired/Sluggish
- ☐ Too hot/cold
- ☐ Excessive thirst

Hematologic/Lymphatic

- ☐ Blood clotting problem
- ☐ Swollen glands

Allergic/Immunologic

- ☐ Drug allergies
- ☐ Hay fever
- ☐ Shellfish/Strawberries

Cardiovascular

- ☐ Chest pain
- ☐ Abnormal heart pain
- ☐ High blood pressure

Psychologic

- ☐ Are you generally satisfied with your life?
- ☐ Do you feel severely depressed?
- ☐ Have you ever considered suicide?

PLEASE ADD ANYTHING BELOW WHICH YOU FEEL WILL HELP US WITH YOUR MEDICAL CARE:

Thank you for assisting in your Health Information.

PATIENT NAME_____ **DOB**_____