BaylorScott&White
CENTER FOR RECONSTRUCTIVE UROLOGY
A member of HealthTexas Provider Network

PATIENT HEALTH QUESTIONNAIRE

Patient Name: ________________________________ **DOB:**____________ **Sex: M / F**

A. **Chief Complaint** (the main reason for seeking medical attention):

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B. PHYSICIAN INFORMATION:

Type of visit: Consultation requested by another Physician Self-referred Second Opinion

Were you referred to Baylor Scott and White Health by a physician? Yes No

Primary Care: ____

Address: ____

Phone: ________________________________ Fax: ___________________________

Referring Physician: ____

Address: ____

Phone: ________________________________ Fax: ___________________________

C. **HISTORY OF PRESENT ILLNESS** briefly description your symptoms, when they started and treatment you have received.

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D. **Allergies:** Please list all medications to which you are allergic. Include any reactions you have had to x-ray dyes (Iodine).

MEDICATION	TYPE OF REACTION

E. PREFERRED PHARMACY:

Name of local Pharmacy:____

Address:____

Phone Number:____

Mail Order Pharmacy:____

Phone: ______________________ Fax: ______________________

F. **Medications:** List all medications you are currently taking (including vitamins and all non-prescription drugs). Copy names and dosages of medication from the prescription label. Please bring all medications with you to your first appointment.

MEDICATION	DOSE (MGS,Tablets)	HOW OFTEN

G. **PAST MEDICAL HISTORY:** Adult Illnesses: Have you ever had any of the following?

Anemia		Elevated PSA		Multiple Sclerosis	
Arthritis		Hepatitis C		Pheumonia	
Asthma		HIV/AIDS		PVS	
Cancer		Hypertension		Seizures	
Clotting Disorder		Infertility		Spina Bifida	
Colon Polyps		Inflammatory Bowel Disease		Sexually Transmitted Infection (STI)	
COPD		Kidney Disease		Stroke	
CAD		Kidney Stones		Ulcers	
Depression		Lupus		UTI	
Diabetes		Migraines		Other	

H. PAST SURGICAL HISTORY:

Aneurysm		Gastric Bypass		Prostate Surgery	
Appendectomy		Hernia Repair		Small Intestine Surgery	
Back Surgery		Hysterectomy		Stone Surgery	
C-Section		Joint Replacement		Testicular Removal	
CABG		Kidney Removal		Tonsillectomy	
Carotid Artery Angioplasty/ Stent		Kidney Transplant		Tubal Ligation	
Cholecystectomy		Lithotripsy (ESWL)		Urinary Diversion	
Colon Surgery		Oophorectomy		Valve Replacement	
Cystoscopy		Penile Surgery		Vasectomy	

Other: ____

I. FAMILY HISTORY:

Alcohol Abuse	Mother		Father		Other	
Anesthesia Problems	Mother		Father		Other	
Clotting Disorder	Mother		Father		Other	
Diabetes	Mother		Father		Other	
Heart Disease	Mother		Father		Other	
Hypertension	Mother		Father		Other	
Kidney Cancer	Mother		Father		Other	
Kidney Disease	Mother		Father		Other	
Urolithiasis (Urinary Stones)	Mother		Father		Other	
Stroke	Mother		Father		Other	

Other Family History:

____

J. SOCIAL HISTORY

Tobacco Use: ☐ Yes ☐ Not Currently ☐ Never

Type: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic Cigarettes ☐ Snuff ☐ Chew

Year Started:_________ Packs/day:_________ Quit Date: _________

Alcohol Use: ☐ Yes ☐ Not Currently ☐ Never

Number of Drinks/Week: ______Glasses of Wine ______Cans of Beer _______Shots of Liquor

Drug Use: ☐ Yes ☐ Not Currently ☐ Never

Type of Drugs:______________________Quit Date:_________________

Sexually Active: ☐ Yes ☐ Not currently ☐Never

Type of Birth Control: _______________________ Partners: ☐ Female ☐ Male ☐ Both