

## The Florida Urology Center 2012 Patient Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

What is your reason for seeing the doctor? \_\_\_\_\_

What questions would you like to ask the doctor? \_\_\_\_\_

Have you ever been treated for alcoholism:

\_\_\_ YES \_\_\_ NO

Have you ever been treated for drug abuse:

\_\_\_ YES \_\_\_ NO

Have you ever had a blood transfusion?

\_\_\_ YES \_\_\_ NO

LIST ALL MEDICATIONS/DOSAGES

ALLERGY HISTORY	YES	NO
Aspirin		
Codeine		
Morphine		
Mycins		
Penicillin		
Sulfa		
Tetracycline		
Other		
Explain:		

PERSONAL HISTORY	YES	NO
Arthritis		
Diabetes		
Gonorrhea/Syphilis		
Hayfever/Asthma		
Heart Disease/Stroke		
Hernia		
High/Low Blood Pressure		
Neuritis		
Paralysis		
Cancer		
Explain:		

SURGICAL HISTORY	YES/DATE	NO
Appendix		
Gall Bladder		
Hemorrhoid		
Hernia		
Prostate		
Ovary(ies)		
Uterus		
Other		
Explain:		