MedStar Georgetown
University Hospital

MedStar Georgetown Urology
MEDICAL HISTORY QUESTIONNAIRE

For Office Use Only

First Name: ______________ Last Name: ______________ DOB: ________ Date: ________

Pharmacy Name: ______________ Pharmacy Address: ______________

Pharmacy Phone Number: ______________ Pharmacy Fax Number: ______________

Name of Physician who Referred you to this Office: ______________

Current Physicians	Address	Phone #	Fax #	Specialty
1.				
2.				
3.				

MEDICATIONS *(List all* ***Prescription*** *drugs you are taking with dosage and schedule)*

1. ______________ 5. ______________

2. ______________ 6. ______________

3. ______________ 7. ______________

4. ______________ 8. ______________

List all ***Non-Prescription*** *drugs:*

Vitamins: ______________ Aspirin / Ibuprofen: ______________

Antacids: ______________ Supplements: ______________

Other: ______________

ALLERGIES *(List all allergies to drugs or foods (i.e., sulfa, shellfish))* ❑ No Known Allergies

1. ______________ 3. ______________

2. ______________ 4. ______________

CHIEF COMPLAINT *(Why do you want to see the doctor?)*

How long have you had this complaint? ______________

Height: ________ ft ________ in Weight: ________ lbs

SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced # of children: ________ Ages: ________

Occupation: ______________ Exercise?. . . . . . ❑ Yes ❑ No Type: ________

Current Tobacco use? . . . . ❑ Yes ❑ No Prior Tobacco use?. . . . . ❑ Yes ❑ No

Alcohol use? . . . . ❑ Yes ❑ No Current Drug use? . . . . ❑ Yes ❑ No Type: ________

Caffeine use? (Cups / Day): Coffee: ________ Tea: ________ Cola: ________

Artificial Sweetener use? . . ❑ Yes ❑ No Type: ______________

PATIENT HISTORY *(Do you have any of the following:)*

Asthma . . . . ❑ Yes ❑ No
Atrial Fibrilation . . . . ❑ Yes ❑ No
Cancer . . . . ❑ Yes ❑ No
Type: ____________________
CVA / Stroke . . . . ❑ Yes ❑ No
Depression . . . . ❑ Yes ❑ No
Diabetes . . . . ❑ Yes ❑ No
DVT . . . . ❑ Yes ❑ No
Heart Disease . . . . ❑ Yes ❑ No
Hepatitis . . . . ❑ Yes ❑ No
Hyperlipidemia . . . . ❑ Yes ❑ No
Hypertension . . . . ❑ Yes ❑ No
Liver Disease . . . . ❑ Yes ❑ No
Neurologic Disorder . . . . . ❑ Yes ❑ No
Osteoarthritis . . . . ❑ Yes ❑ No
Peripheral Vascular Disease . . ❑ Yes ❑ No
Thyroid Disorder . . . . ❑ Yes ❑ No
Tuberculosis . . . . ❑ Yes ❑ No
UTI Recurrent . . . . ❑ Yes ❑ No
Vascular Disease . . . . ❑ Yes ❑ No
❑ No Medical Problems

Other Medical Problems: ____________________

Previous Hospitalizations for Medical Problems: ❑ No ❑ Yes. If yes, type and date: ____________________

____

PREVIOUS SURGERIES: ❑ No ❑ Yes. If yes, please complete the below.

Type	Date	Type	Date

FAMILY HISTORY *(Check illnesses which have occurred in any blood relative and write relationship to you)*

❑ Alcoholism ____________________
❑ Arthritis ____________________
❑ Bleeding Disorders ____________________
❑ Cancer (Type) ____________________
❑ Coronary Heart Disease ____________________
❑ CVA or Stroke ____________________
❑ Depression ____________________
❑ Diabetes ____________________
❑ DVT ____________________
❑ High Blood Pressure ____________________
❑ High Cholesterol ____________________
❑ Kidney Disease ____________________

REVIEW OF SYSTEMS *(Do you now have or have you ever had)*

GENERAL COMPLAINTS

Fever? . . . . ❑ Yes ❑ No
Fatigue / Weakness? . . . . ❑ Yes ❑ No
Chills? . . . . ❑ Yes ❑ No
Weight Loss? . . . . ❑ Yes ❑ No
Weight Gain? . . . . ❑ Yes ❑ No

GU COMPLAINTS

Pain with Urination? . . . . . ❑ Yes ❑ No
Urine Hesitancy? . . . . ❑ Yes ❑ No
Blood in Urine? . . . . ❑ Yes ❑ No
Urine Frequency? . . . . . . ❑ Yes ❑ No
Urinating at Night? . . . . . . ❑ Yes ❑ No
Decreased Libido? . . . . . . ❑ Yes ❑ No
Erectile Dysfunction? . . . . ❑ Yes ❑ No
Incontinence? . . . . ❑ Yes ❑ No

CARDIOVASCULAR COMPLAINTS

Chest Pains? . . . . ❑ Yes ❑ No
Palpitations? . . . . ❑ Yes ❑ No

RESPIRATORY COMPLAINTS

Cough? . . . . ❑ Yes ❑ No
Coughing up Blood? . . . . ❑ Yes ❑ No

GI COMPLAINTS

Nausea? . . . . ❑ Yes ❑ No
Constipation? . . . . ❑ Yes ❑ No
Change in Bowel Habits? ❑ Yes ❑ No
Vomiting? . . . . ❑ Yes ❑ No
Abdominal Pain? . . . . ❑ Yes ❑ No
Diarrhea? . . . . ❑ Yes ❑ No
Blood in Stool? . . . . ❑ Yes ❑ No

NEUROLOGICAL COMPLAINTS

Seizures? . . . . ❑ Yes ❑ No
Frequent Headaches? . . . ❑ Yes ❑ No

ENDO COMPLAINTS

Polyuria? . . . . ❑ Yes ❑ No

MSK COMPLAINTS

Back Pain? . . . . ❑ Yes ❑ No
Joint Pain? . . . . ❑ Yes ❑ No
Muscle Weakness? . . . . . ❑ Yes ❑ No

DERMATOLOGICAL COMPLAINTS

Rash? . . . . ❑ Yes ❑ No
Itching? . . . . ❑ Yes ❑ No

PSYCHOLOGICAL COMPLAINTS

Depression? . . . . ❑ Yes ❑ No
Anxiety? . . . . ❑ Yes ❑ No
Memory Loss? . . . . ❑ Yes ❑ No

HEMATOLOGY COMPLAINTS

Abnormal Bruising? . . . . . ❑ Yes ❑ No
Bleeding? . . . . ❑ Yes ❑ No

ALLERGY COMPLAINTS

Allergic Rash? . . . . ❑ Yes ❑ No
Recurrent Infections? . . . ❑ Yes ❑ No

EYE COMPLAINTS

Blurring & Vision Loss? . . ❑ Yes ❑ No

ENT COMPLAINTS

Decreased Hearing? . . . . ❑ Yes ❑ No
Nose Bleeds? . . . . ❑ Yes ❑ No

ANY OTHER COMPLAINTS:

Form Completed By: ____________________ Date: ____________