CENTRAL JERSEY UROLOGY ASSOCIATES, LLC

Initial Patient Questionnaire

Name _____ Sex _____ Date _____

(First) (Last)

PERSONAL:

Occupation:

Marital Status: M S W D

Allergies to Medication:

CURRENT MEDICATIONS:

_____
_____
_____
_____

FAMILY HISTORY:

Mother _____ Alive _____

Deceased at age _____

Cause of death _____

Father _____ Alive _____

Deceased at age _____

Cause of death _____

Immediate family members with history of:

_____ Diabetes
_____ Prostate Cancer
_____ Kidney Disease
_____ Heart Disease
_____ Kidney Stones
_____ Mental Illness

SOCIAL HABITS:

Presently	In past	
_____	_____	Smoke cigarettes, cigars, pips
		Packs/day _____
_____	_____	use recreational drugs
_____	_____	Drink Alcohol
		____ Occasionally
		____ Daily Amount_____

CHILDHOOD ILLNESSES:

_____ Whooping Cough
_____ German Measles
_____ Rheumatic Fever
_____ Measles
_____ Mumps
_____ Asthma

DO YOU HAVE ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS? (Circle Yes or No)

Urinary		**Hematological/Lymphatic**		**Psychological**	
Urine Retention	Y N	Swollen Glands	Y N	Do you fell severely depressed?	Y N
Painful Urination	Y N	Blood Clotting Problem	Y N	Have you considered suicide?	Y N
Urinary Frequency	Y N	Other	Y N	Other	Y N
Blood in the Urine	Y N				
Incontinence of Urine	Y N				
Neurological		**Endocrine**		**Gynecological (Women Only)**	
Tumors	Y N	Excessive Thirst	Y N	Menopause	Y N
Dizzy Spells	Y N	Too hot/cold	Y N	Could you be pregnant	Y N
Numbness/Tingling	Y N	Diabetes	Y N	Other	Y N
Other	Y N	Other	Y N		
Gastrointestinal		**Cardiovascular**		**Integumentary**	
Abdominal Pain	Y N	Heart Disease	Y N	Skin Rash	Y N
Nausea/Vomiting	Y N	Heart Murmur	Y N	Hives	Y N
Indigestion/Heartburn	Y N	High Blood Pressure	Y N	Persistent Itch	Y N
Other	Y N	Other	Y N	Other	Y N
Musculoskeletal		**Respiratory**		**Constitutional**	
Joint Pain	Y N	Wheezing	Y N	Fever	Y N
Back Pain	Y N	Frequent Cough	Y N	Chills	Y N
Arthritis	Y N	Shortness of Breath	Y N	Others	Y N
Other	Y N	Others	Y N		

Patient Sign: _____ **Date**: _____ **Dr. Sign** _____