UROLOGY CENTER OF SOUTH FLORIDA,P.A.

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NEW PATIENT MEDICAL QUESTIONNAIRE

Print Name____

Today's Date_______________________ Date of Birth_____________________________

Why did you choose the Urology Center of South Florida? ______________________________

If referred, by whom?____

HAVE YOU **EVER** HAD ANY OF THE FOLLOWING CONDITIONS?

YES	NO	NOT SURE	Condition	YES	NO	NOT SURE	Condition
☐	☐	☐	Diabetes Mellitus (sugar)	☐	☐	☐	Glaucoma
☐	☐	☐	High blood pressure (hypertension)	☐	☐	☐	Other eye disease
☐	☐	☐	High cholesterol	☐	☐	☐	Sinus problems
☐	☐	☐	Heart disease	☐	☐	☐	Hay fever
☐	☐	☐	Heart attack	☐	☐	☐	Skin disease
☐	☐	☐	Atrial fibrillation	☐	☐	☐	SLE or connective disease
☐	☐	☐	Cardiac arrhythmia (irregular heartbeat)	☐	☐	☐	Gout
☐	☐	☐	Heart murmur	☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Congestive heart failure	☐	☐	☐	Osteoarthritis
☐	☐	☐	Cancer (any type)	☐	☐	☐	Osteoporosis
☐	☐	☐	Emphysema	☐	☐	☐	Disease of the spine
☐	☐	☐	Chronic bronchitis	☐	☐	☐	Sciatica
☐	☐	☐	COPD (lung disease)	☐	☐	☐	Other musculoskeletal disorder
☐	☐	☐	Asthma	☐	☐	☐	Anemia
☐	☐	☐	Other respiratory problem	☐	☐	☐	Disorders of blood or lymph
☐	☐	☐	Thyroid disorder	☐	☐	☐	Stroke
☐	☐	☐	Other endocrine disorder	☐	☐	☐	Ministroke/TIA
☐	☐	☐	Poor circulation	☐	☐	☐	Cerebral aneurysm
☐	☐	☐	Peripheral vascular disease	☐	☐	☐	Parkinson's disease
☐	☐	☐	Aneurysm of aorta	☐	☐	☐	Alzheimer's disease
☐	☐	☐	Gastritis	☐	☐	☐	Tremors
☐	☐	☐	Peptic ulcer	☐	☐	☐	Peripheral neuropathy
☐	☐	☐	Diverticulosis	☐	☐	☐	Shingles/Herpes Zoster
☐	☐	☐	Diverticulitis	☐	☐	☐	Kidney disease
☐	☐	☐	Other gastrointestinal disorder	☐	☐	☐	Kidney stones
☐	☐	☐	Liver disease or hepatitis	☐	☐	☐	Aids or HIV positivity

OTHER____

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DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS?

YES	NO		YES	NO	
☐	☐	Weakness/fatigue	☐	☐	Poor eyesight
☐	☐	Unexplained weight loss	☐	☐	Other eye problems
☐	☐	Frequent headaches	☐	☐	Poor hearing
☐	☐	Excessive thirst	☐	☐	Throat pain/hoarseness
☐	☐	Intolerance to heat or cold	☐	☐	Trouble swallowing
☐	☐	Any abnormal lumps or masses	☐	☐	Frequent earaches
☐	☐	Poor appetite/eating disorder			
☐	☐	Chest pain/angina	☐	☐	Heartburn/indigestion
☐	☐	Palpitations	☐	☐	Flatulence/gas pain
☐	☐	Frequent shortness of breath	☐	☐	Abdominal/belly pain
☐	☐	Difficulty breathing while lying flat	☐	☐	Nausea or vomiting
☐	☐	Wheezing	☐	☐	Constipation
☐	☐	Frequent cough	☐	☐	Diarrhea
☐	☐	Fainting or dizzy spells	☐	☐	Blood in stool
☐	☐	Swelling of legs/ankles	☐	☐	Black or tarry stools
☐	☐	Pain in legs with walking			
☐	☐	Non-healing sores on legs, feet, or toes			
☐	☐	Varicose veins			
☐	☐	Insomnia	☐	☐	Swelling, pain, or deformity of joints
☐	☐	Poor memory	☐	☐	Lower back pain
☐	☐	Tremors	☐	☐	Upper back pain
☐	☐	Paralysis	☐	☐	Head/shoulder pain
☐	☐	Anxiety, nervousness	☐	☐	Pain of arms/legs
☐	☐	Depression	☐	☐	Muscle weakness
			☐	☐	Muscle cramps

Please list all surgeries or procedures you have had and date: ______________________

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Please list all of your current medications: ____________________________________

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List any medication allergies or any medications you cannot tolerate: _______________

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Please list you other physicians and their specialty: ______________________________

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Form 63B

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Patient Signature