Incontinence Centers of America
REGAIN YOUR CONTROL

PATIENT HEALTH QUESTIONAIRE

Patient Name: _____ **Sex:**_____
Last First Middle Initial

Phone Number: ____-____-____ **E-Mail:**_____

Date of Birth: _______________ **Age:**_____ **Social Sec #:**_____-_____-_____

Type of visit: ☐ Consultation requested by another physician ☐ Self-referred

A. PHYSICIAN INFORMATION:

Were you referred to us by a physician? ☐ Yes ☐ No

Primary Care Physician: _____
Address: _____
Phone : _____ Fax: _____

Referring Physician: _____ Specialty: _____
Address: _____
Phone : _____ Fax: _____

Have you seen a Urologist? ☐ **Yes** ☐ **No**

Name: _____ Fax: _____

B. CHIEF COMPLAINT: (the main reason for seeking medical attention.)

_____

C. HISTORY OF PRESENT ILLNESS: (Briefly describe your symptoms, when they started, and treatment you have received.)

_____

D. SOCIAL HISTORY:

Alcohol Use ☐ Never ☐ Occasional ☐ Daily ☐ History of Alcoholism

Tobacco Use ☐ Never ☐ Occasional ☐ Daily How many packs per week: _____

Drug Use ☐ Never ☐ Occasional ☐ Daily History of Drug use, What Drug?: _____

Any problems with prescription medication misuse, abuse, addiction?

What is your current work status? ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Occupation (if employed): _____

E. 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

F. MEDICATIONS

List any medications you are now 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 visit.

NAME OF MEDICATION	DOSE (MGS, tablets)	HOW OFTEN

G. PREFERRED PHARMACY:

Name of Local Pharmacy: _____
Address/Location of Pharmacy: _____
Phone number: _____
Mail Order Pharmacy Name: _____
Mail Order Pharmacy Phone Number: _____
Mail Order Pharmacy Fax Phone Number: _____
Mail Order Pharmacy ID #: _____

H. PAST MEDICAL HISTORY: Please check the following medical conditions you have or have had in the past.

Head/Eyes/Ears/Nose/Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Cancer
- ☐ Pneumonia

Cardiovascular
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Murmur
- ☐ Mitral Valve Prolapse
- ☐ Coronary Artery Disease
- ☐ Pacemaker
- ☐ Defibralator
- ☐ Peripheral Vascular Disease
- ☐ Deep Vein Thrombosis

Hematologic
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Bleeding Disorder
- ☐ High Cholesterol
- ☐ Protein C/S Deficiency
- ☐ Systemic Lupus Erythematosus
- ☐ Lymphoma
- ☐ Leukemia

Gastrointestinal
- ☐ Gastritis
- ☐ Gastric Ulcers
- ☐ GERD (acid reflux)
- ☐ Bowel Incontinence
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Liver Cancer
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Diabetes Type I
- ☐ Diabetes Type II

Musculoskeletal
- ☐ Amputation
- ☐ Phantom Limb Pain
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Vertebral Body Fracture

Genitourinary/Kidney
- ☐ Kidney Disease
- ☐ Kidney Cancer
- ☐ Acute Renal Failure
- ☐ Chronic Renal Failure
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Neurological
- ☐ Multiple Sclerosis
- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Restless Leg Syndrome
- ☐ Epilepsy/Seizures
- ☐ Trigeminal Neuralgia
- ☐ Peripheral Neuropathy

Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Prescription Drug Abuse
- ☐ Illegal Drug Abuse
- ☐ Alcohol Abuse

Please list any other medical conditions you have had that are not listed above:

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I. REVIEW OF SYSTEMS: Please select all that apply.

NAME: _____ **DATE OF BIRTH:** **DATE:**

CONSTITUTIONAL
- ☐ Activity Change
- ☐ Decreased Appetite
- ☐ Fatigue
- ☐ Fever
- ☐ Insomnia
- ☐ Irritability
- ☐ Malaise
- ☐ Night Sweats
- ☐ Recent weight gain
- ☐ Recent weight loss

HEENT
- ☐ Headaches
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Ear Infections
- ☐ Vertigo
- ☐ Nose Bleeds
- ☐ Sinus Infections
- ☐ Difficulty Swallowing
- ☐ Sore Throats

RESPIRATORY
- ☐ Pain during breathing
- ☐ Cough
- ☐ Bloody Sputum
- ☐ Known TB Exposure
- ☐ Snoring
- ☐ Wheezing
- ☐ Respiratory Infections

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Lower Leg Swelling
- ☐ Palpitations
- ☐ Fainting Spells

VASCULAR
- ☐ Leg Cramping
- ☐ Swelling
- ☐ Pain
- ☐ Leg Ulcer
- ☐ Varicose Veins
- ☐ Blood clots

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Indigestion/Heartburn
- ☐ Jaundice
- ☐ Nausea
- ☐ Reflux

URINARY
- ☐ Back Pain
- ☐ Change in Urine Color
- ☐ Cloudy Urine
- ☐ Decreased Stream
- ☐ Painful Urination
- ☐ Flank Pain
- ☐ Frequency
- ☐ Groin Mass
- ☐ Blood in Urine
- ☐ Hesitancy
- ☐ Incontinence
- ☐ Low Urine Output
- ☐ Get Up at Night to Urinate
- ☐ Passing Stones
- ☐ Excessive Urination
- ☐ Urgency

REPRODUCTIVE MALE
- ☐ Penile Discharge
- ☐ Blood in Ejaculate
- ☐ Testicular Pain
- ☐ Testiicular Mass
- ☐ History of Hydrocele
- ☐ Genital Herpes
- ☐ Infertility
- ☐ Decreased Libido

REPRODUCTIVE FEMALE
- ☐ Pre- Menopausal
- ☐ Peri-Menopausal
- ☐ Menopausal
- ☐ Date of Last Menses
- ☐ Hormone Replacement
- ☐ Uterine Fibroids
- ☐ History of Abnormal Pap
- ☐ Ovarian Cysts
- ☐ Unusual Vaginal Discharge

METABOLIC/ENDOCRINE
- ☐ Cold/Heat Intolerance
- ☐ Excessive Perspiration
- ☐ Goiter
- ☐ Infertility
- ☐ Low Blood Sugar
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Excessive Urination

NEUROLOGIC/PSYCHIATRIC
- ☐ Altered Speech
- ☐ Focal Weakness
- ☐ Gait Disturbance
- ☐ Loss of Coordination
- ☐ Light-Headed/Dizziness
- ☐ Loss of Consciousness/Fainting
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Tremors

SKIN (DERMATOLOGIC)
- ☐ Contact Allergies
- ☐ Itching
- ☐ Rash
- ☐ Light Sensitivity
- ☐ Skin Lesions

MUSKOSKELETAL
- ☐ Back Pain
- ☐ Joint/Bone Pain/Swelling
- ☐ Muscle Pain
- ☐ Rheumatolgic Issues
- ☐ Weakness

BLOOD FORMING (HEMATOLOGIC)
- ☐ Easy Bruising
- ☐ Easy Beeding
- ☐ Blood Clots
- ☐ Low Blood Counts
- ☐ Swollen Glands

IMMUNE SYSTEM
- ☐ Asthma
- ☐ Contact Dermatitis
- ☐ Food Allergies
- ☐ Bee Sting Allergies
- ☐ Environmental Allergies

J. PAST SURGICAL HISTORY:

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

K. FAMILY HISTORY

- ☐ Bedwetting Age at onset:
- ☐ Diabetes Age at onset:
- ☐ Kidney Failure Age at onset:
- ☐ Kidney Stones Age at onset:
- ☐ Prostate Cancer Age at onset:

Other Family History:

_____