HUNTERDON UROLOGICAL ASSOCIATES
New Patient Questionnaire

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

Allergies: _____

Chief Complaint: _____

HISTORY OF PRESENT ILLNESS: *(list any personal past illnesses and/or surgeries and when they occurred)* _____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

TOBACCO: Never _____ Presently (Packs/Day) _____ Quit (Age and Packs/Day) _____

ALCOHOL: Never _____ Social (Drinks/Day) _____ Daily (Drinks/Day) _____

CAFFEINE: _____ cup/s per day

RECREATIONAL DRUGS: Yes:_____ No:_____

Immediate Family Members (Parents, Siblings) with history of any Cancer or Chronic Diseases:

Family Member: _____ Disease: _____

Family Member: _____ Disease: _____

Family Member: _____ Disease: _____

Family Member: _____ Disease: _____

Please review the following Review of Systems, and check off any symptoms that have affected your current and prior health. If you have not experienced symptoms in a particular system, check "None".

CONSTITUTIONAL
- ○ None
- ○ Weight Loss/Gain
- ○ Fatigue
- ○ Fever/Chills, Sweats
- ○ Other

PSYCHIATRIC
- ○ None
- ○ Depression
- ○ Anxiety
- ○ Other

MUSCULOSKELETAL
- ○ None
- ○ Joint Pain/Arthritis
- ○ Low Back Pain
- ○ Joint Pain
- ○ Other

RESPIRATORY
- ○ None
- ○ Chronic Cough
- ○ Known TB Exposure
- ○ Wheezing
- ○ Asthma
- ○ Sleep Apnea
- ○ Other

GENITOURINARY
- ○ None
- ○ Dysuria
- ○ Sexual Dysfunction
- ○ Hematuria-blood in urine
- ○ Urinary Frequency
- ○ Urinary Incontinence
- ○ Urinary Retention
- ○ Other

METABOLIC/ENDOCRINE
- ○ None
- ○ Diabetes
- ○ Thyroid Disease
- ○ Adrenal Disease
- ○ Cold Intolerance
- ○ Excessive Thirst
- ○ Fatigue
- ○ Heat Intolerance
- ○ Other

GASTROINTESTINAL
- ○ None
- ○ Abdominal Pain
- ○ Blood in Stool
- ○ Constipation/Diarrhea
- ○ Heartburn
- ○ Loss of Appetite
- ○ Nausea/Vomiting
- ○ Other

PATIENT'S SIGNATURE:_____ **DATE:** _____