THE UROLOGY CENTER OF CHESTER COUNTY, P.C.

NEW PATIENT QUESTIONNAIRE

Date: ____________________

Name: ____________________ Age: ________ Referring Doctor: ____________________

What is the main reason that you are seeing the doctor today?

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PAST MEDICAL HISTORY:

Illnesses: (List any medical conditions you have such as High Blood Pressure, Diabetes, Heart Disease, High Cholesterol, etc...)

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Surgeries: (List any operations you have had and approximately when they were done.)

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Allergies: (List all allergies to Medications, Anesthetics, Contrast agents, etc...)

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Occupation: ____________________

Marital Status: ____________________

Ages and Sex of Children: ____________________

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Cigarettes: (Packs per day) ____________________

Alcoholic Beverages: (Drinks per day) ____________________

Family History: List your parents' age and medical condition if living. If parents deceased, list age and cause of death.

Father ____________________

Mother ____________________

Is there a family history of?:

Prostate Cancer	☐ Yes	☐ No
Kidney Cancer	☐ Yes	☐ No
Bladder Cancer	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No