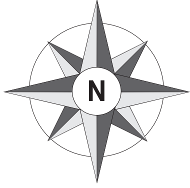

NORTHGATE UROLOGY ASSOCIATES

5325 Northgate Drive, Suite 203 • Bethlehem, PA 18017

610-867-3171 • Fax: 610-867-1941

PATIENT QUESTIONNAIRE

Date ____________________

Name ____ DOB ____________________

Occupation ____ Sex ☐ M ☐ F

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

List all current Medications & Dosages

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Do you have any allergies? ☐ Y ☐ N List ______________________________

Do you smoke? ☐ Y ☐ N Cigars __________ Pipe __________ Tobacco __________ Packs per day __________

Do you use alcohol? ☐ Y ☐ N What kind? ______________ How much? ______________

Have you used recreational drugs? ☐ Y ☐ N

Have you ever had local anesthesia? ☐ Y ☐ N Any problems? ☐ Y ☐ N Explain ______________

Have you ever had any problems with general anesthesia? ☐ Y ☐ N Explain ______________

Do you currently have or ever been treated for any of these medical problems?

			Explanation
Neurologic Condition			
Stroke	☐ Y	☐ N	
TIA	☐ Y	☐ N	
Bad Back	☐ Y	☐ N	
Parkinson’s Disease	☐ Y	☐ N	
Tremors	☐ Y	☐ N	
Other Neurologic	☐ Y	☐ N	
Cardiac			
Heart Attack	☐ Y	☐ N	
Heart Failure	☐ Y	☐ N	
Heart Valve Problem	☐ Y	☐ N	
Irregular Heart Beat	☐ Y	☐ N	
Angina (Chest Pains)	☐ Y	☐ N	

Questionnaire continued on second page

Medical Problems (con't)

Medical Problems (con't)	Y	N	Explanation
Lung Problems	☐ Y	☐ N	
Diabetes	☐ Y	☐ N	
High Blood Pressure	☐ Y	☐ N	
Liver Problems/Hepatitis	☐ Y	☐ N	
Thyroid Problems	☐ Y	☐ N	
Stomach Problems	☐ Y	☐ N	
Bowel Problems	☐ Y	☐ N	
Kidney Problems	☐ Y	☐ N	
Kidney Stones	☐ Y	☐ N	
Arthritis Problems	☐ Y	☐ N	
Any Weight Loss	☐ Y	☐ N	
Orthopedic Problems	☐ Y	☐ N	
Mental Health Issues	☐ Y	☐ N	
Past History of Cancer	☐ Y	☐ N	
Sexual Dysfunction	☐ Y	☐ N	

List Past Surgical History (Operations)

Type	Date	Hospital

Family History (Check if any have been affected)

	Father	Mother	Brother(s)	Sister(s)
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Kidney Disease				
Cancer (List Kind)				
Gout				
Kidney Stones				
Tuberculosis				
Hepatitis				

Any Past history of kidney, bladder or other urologic problems? ☐ Y ☐ N

Explain ____