SOUTHEAST VALLEY UROLOGY
A DIVISION OF IRONWOOD PHYSICIANS, P.C.

HEALTH QUESTIONAIRE

What is the purpose of your visit today?
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Have you had or have any of the follow:

__Heart Problem	__Radiation Treatments	__Cerebral Palsy	__Arthritis
__High Blood Pressure	__Tonsils Removed	__Scarlet Fever	__Gout
__Low Blood Pressure	__Adenoids Removed	__Epilepsy	__HIV/AIDS
__Circulatory Problems	__Gallbladder Problems	__Cancer	__HTLV
__Alcoholism	__Chronic Ear Infections	__STD's	__Ulcers
__Excessive Bleeding	__Chronic Fatigue	__Dizziness/ Fainting	__Diabetes
__Rheumatic Fever	__Shortness of Breath	__Nervous Problems	__Anemia
__Kidney Problems	__Liver Problems	__Tuberculosis	__Hepatitis
__Allergies/Hay Fever	__Chronic Sinus Problems	__Asthma	__Kidney Stones

Other health problems not listed above? ____
____

Is there a family history of any of the health issues listed above? YES / NO
If yes, please list which problem and family member had them: (mother, father, grandparent, brother, sister, etc)
____
____

Please list ALL medications that you are currently taking (if you have a list please attach):
____
____

DO YOU HAVE ANY DRUG ALLERGIES? YES / NO
If yes, please list the name of the drug and the symptom that occurs when it is taken
(hives, itching, shortness of breath, etc)
____
____

Have you ever been hospitalized? YES / NO If yes, please list reason and date?
____
____

If you are a female, are you pregnant? YES / NO If yes, how many months? ______________________

Last mammogram: ____________ Last colonoscopy: ____________ Last DEXA scan: _____________

Signature of person giving this history____

Date__________________________ Relationship to patient_________________________________