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Welcome to our practice. As a new or re-established patient, we need to develop and review your medical history database. In preparation for your office visit, we kindly ask that you fill out this questionnaire to the best of your ability. The form may seem lengthy but should expedite your evaluation and treatment as we seek solutions to your particular problem.

Patient Name: _____ Date of Birth: _____

Email Address: _____

Chief Complaint: _____ Primary Care Physician: _____

History of Present Illness:

- Location _____
  (Where is the pain/problem?)
- Quality _____
  (Example: normal versus abnormal color, activity, etc.)
- Severity _____
  (How severe is the pain/problem on a scale of 1-5, 5 being the most severe?)
- Duration _____
  (How long have you had this pain/problem? or When did it start?)
- Timing _____
  (Does this pain/problem occur at a specific time?)
- Context _____
  (Where were you at the onset of this pain/problem?)
- Associated signs/symptoms _____
  (What other associated problems have you been having?)
- Modifying factors _____
  (What makes the pain/problem worse or better? Or have you had previous episodes?)

Medical History:

Patient Medical History:

Diabetes	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart Trouble	No	Yes
Arthritis/gout	No	Yes
Convulsions	No	Yes
Bleeding Tendency	No	Yes
Acute infections	No	Yes
Venereal Disease	No	Yes
Hereditary Disease	No	Yes

Other:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgical History	**Date Occurred**
_____	_____
_____	_____
_____	_____

Social History:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol	Never	Rarely	Moderate	Daily	
Use of Tobacco	Never	Previously, but quit: _____		Current packs/day: _____	
Use of Drugs	Never	Type/Frequency: _____			

Family Medical History:

	Age	Living or Deceased		Significant medical problems
Father	_____	L	D	_____
Mother	_____	L	D	_____
Siblings	_____	L	D	_____
	_____	L	D	_____
	_____	L	D	_____
Spouse	_____	L	D	_____
Children	_____	L	D	_____
	_____	L	D	_____

Your Current Medications and Dosages:

This section is not needed if your PCP is a Mercy Physician

	Currently Taking?	
_____	Y	N
_____	Y	N
_____	Y	N
_____	Y	N
_____	Y	N
_____	Y	N
_____	Y	N
_____	Y	N
_____	Y	N
_____	Y	N
_____	Y	N

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS
Good general health lately ..... No Yes
Recent weight change ..... No Yes
Fever ..... No Yes
Fatigue ..... No Yes
Headaches ..... No Yes

EYES
Eye disease or injury ..... No Yes
Wear glasses/contacts ..... No Yes
Blurred or double vision ..... No Yes
Glaucoma ... **Wide Angle / Narrow Angle** ..... No Yes

EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing..... No Yes
Earaches or drainage ..... No Yes
Chronic sinus problem or rhinitis ..... No Yes
Nose bleeds ..... No Yes
Mouth sores ..... No Yes
Bleeding gums ..... No Yes
Bad breath or bad taste ..... No Yes
Sore throat or voice change ..... No Yes
Swollen glands in neck ..... No Yes

CARDIOVASCULAR
Heart trouble ..... No Yes
Chest pain or angina pectoris ..... No Yes
Palpitations ..... No Yes
Shortness of breath with walking or lying flat ... No Yes
Swelling of feet, ankles or hands ..... No Yes

RESPIRATORY
Chronic or frequent coughs ..... No Yes
Spitting up blood ..... No Yes
Shortness of breath ..... No Yes
Asthma or wheezing ..... No Yes

GASTROINTESTINAL
Loss of appetite ..... No Yes
Change in bowel movements ..... No Yes
Nausea or vomiting ..... No Yes
Frequent diarrhea ..... No Yes
Painful bowel movements or constipation ..... No Yes
Rectal bleeding or blood in stool ..... No Yes
Abdominal pain ..... No Yes
Peptic ulcer (stomach or duodenal) ..... No Yes

GENITOURINARY
Frequent urination ..... No Yes
Burning or painful urination ..... No Yes
Blood in urine ..... No Yes
Change in force of stream when urinating .....No Yes
Incontinence or dribbling ..... No Yes
Kidney stones ..... No Yes
Sexual difficulty ..... No Yes
Male – testicle pain ..... No Yes
Female – pain with periods ..... No Yes
Female – irregular periods ..... No Yes
Female – vaginal discharge ..... No Yes
Female - # of pregnancies ..... _____
Female - # of miscarriages ..... _____
Female – date of last pap smear ..... _____

MUSCULOSKELETAL
Joint pain ..... No Yes
Joint stiffness ..... No Yes
Weakness of muscles or joints ..... No Yes
Muscle pain or cramps ..... No Yes
Back pain ..... No Yes
Cold extremities ..... No Yes
Difficulty in walking ..... No Yes

INTEGUMENTARY (skin and breast)
Rash or itching ..... No Yes
Change in skin color ..... No Yes
Change in hair or nails ..... No Yes
Varicose veins ..... No Yes
Breast pain ..... No Yes
Breast lump ..... No Yes
Breast discharge ..... No Yes
Date of last mammogram ..... _____

NEUROLOGICAL
Frequent or recurring headaches ..... No Yes
Light headedness or dizziness ..... No Yes
Convulsions or seizures ..... No Yes
Numbness or tingling sensations ..... No Yes
Tremors ..... No Yes
Paralysis ..... No Yes
Stroke ..... No Yes
Head injury ..... No Yes

PSYCHIATRIC
Memory loss or confusion ..... No Yes
Nervousness ..... No Yes
Depression ..... No Yes
Insomnia ..... No Yes

ENDOCRINE
Glandular or hormone problem ..... No Yes
Thyroid disease ..... No Yes
Diabetes (insulin or non-insulin – circle one)..... No Yes
Excessive thirst or urination ..... No Yes
Heat or cold intolerance ..... No Yes
Skin becoming drier ..... No Yes
Change in hat or glove size ..... No Yes

HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts ..... No Yes
Bleeding or bruising tendency ..... No Yes
Anemia ..... No Yes
Phlebitis ..... No Yes
Past transfusion ..... No Yes
Enlarged glands ..... No Yes

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
Penicillin ..... No Yes
Morphine, Demerol or other narcotics ..... No Yes
Novocain or other anesthetics ..... No Yes
Aspirin or other pain remedies ..... No Yes
Tetanus antitoxin or other serums ..... No Yes
Iodine, methiolate or other antiseptic ..... No Yes
Other drugs/medications _____
Known food allergies: _____
Environmental allergies: _____

Bladder Symptom Questionnaire

Name: _____ Date: _____

Doctor: _____ Phone: _____

Date of birth: _____

Which symptoms best describe you? Check all that apply.

- ☐ Frequent urination—day, night, or both
- ☐ Sudden or strong urge to urinate
- ☐ Leakage with little or no warning—sometimes unable to make it to the bathroom in time
- ☐ Unable to completely empty bladder—feels like there is more even after going to the bathroom
- ☐ Accidental leakage with physical activity—exercising, sneezing, or coughing
- ☐ Bladder or pelvic pain
- ☐ Problems with bowel function (if checked, please select symptom below)
  - ☐ Accidental loss or leakage of stool ☐ Constipation ☐ Other
- ☐ No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No
(If yes, please circle which medications you have tried on the back of this sheet.)

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Are you still taking any of these medications? ☐ Yes ☐ No

If no, why have you stopped taking them?

- ☐ Did not work as well as expected
- ☐ Side effects
- ☐ Expense
- ☐ Interaction with other medications
- ☐ Other

If Side effects or Other checked, please explain:

_____

Behavior modifications tried? _____
(i.e, reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Extremely Frustrated***

Are you interested in learning more about additional treatment alternatives to bladder medications?

☐ Yes ☐ No

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