

# **MUROLOGY** Patient Health Questionnaire

MARQUETTE GENERAL

NAME \_\_\_\_\_

Referring Provider \_\_\_\_\_

D.O.B. \_\_\_\_\_

DATE OF EXAM \_\_\_\_\_

## **Past Medical History / Review of Systems**

### **PAST MEDICAL HISTORY**

**SURGERY:** List any operations you have had:

**MEDICAL:** List any serious illness you have had:

**MEDICATIONS:**

**ALLERGIES:**

\_\_\_\_\_  
Signature of person completing questionnaire  
Or patient representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature of Physician  
Or patient representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

Have you ever taken a diuretic (water pill)? \_\_\_\_\_ Have you ever taken cortisone? \_\_\_\_\_

**FAMILY HISTORY: (Parents, Brothers, Sisters, Children) Is there anyone who has or had:**

- a) Cancer \_\_\_\_\_
- b) Nervous emotional problems \_\_\_\_\_
- c) Diabetes \_\_\_\_\_
- d) Heart problems \_\_\_\_\_
- e) High blood pressure \_\_\_\_\_
- f) Urinary problems (stones, infection) \_\_\_\_\_
- g) Bleeding problems \_\_\_\_\_
- h) Asthma or hayfever \_\_\_\_\_

**SOCIAL HISTORY:**

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ Amount: \_\_\_\_\_  
Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ Amount: \_\_\_\_\_  
Have you ever smoked? Yes \_\_\_\_\_ No \_\_\_\_\_ Amount: \_\_\_\_\_  
Have you ever worked in or do you work in a mine, at a sawmill or with asbestos? \_\_\_\_\_

**SYSTEM REVIEW: ENDOCRINE**

- a) Thyroid disease \_\_\_\_\_
- b) Diabetes \_\_\_\_\_
- c) Adrenal disease \_\_\_\_\_

**CHEST: Have you had:**

- a) Tuberculosis \_\_\_\_\_
- b) Emphysema \_\_\_\_\_
- c) Shortness of breath \_\_\_\_\_
- d) Chest pain or angina \_\_\_\_\_
- e) Heart attack \_\_\_\_\_
- f) High blood pressure \_\_\_\_\_
- g) Asthma or hayfever \_\_\_\_\_
- h) Rheumatic fever \_\_\_\_\_
- i) Congestive heart failure \_\_\_\_\_
- j) Blood in sputum \_\_\_\_\_
- k) Bronchitis \_\_\_\_\_
- l) Pneumonia \_\_\_\_\_
- m) Stroke \_\_\_\_\_

**GASTROINTESTINAL: Have you ever had or do you have:**

- a) Jaundice \_\_\_\_\_
- b) Hepatitis \_\_\_\_\_
- c) Mononucleosis \_\_\_\_\_
- d) Liver problems \_\_\_\_\_
- e) Stomach ulcers \_\_\_\_\_
- f) Colitis \_\_\_\_\_
- g) Black tarry stools \_\_\_\_\_
- h) Nausea & vomiting \_\_\_\_\_

**HEMATOLOGIC:**

- a) Bleeding problems \_\_\_\_\_
- b) Leukemia \_\_\_\_\_
- c) Anemia \_\_\_\_\_

**GENITOURINARY: Have you ever had or do you have:**

- a) Difficulty voiding (passing water) \_\_\_\_\_
- b) Kidney or bladder infections \_\_\_\_\_
- c) Blood in urine \_\_\_\_\_
- d) Stones or gravel \_\_\_\_\_
- e) Venereal disease \_\_\_\_\_
- f) Do you get up at night to urinate? \_\_\_\_\_

**Reason for seeing this doctor:**

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had a catheter in? \_\_\_\_\_  
Have you ever had surgery on your kidneys or bladder? \_\_\_\_\_  
If so, what kind? \_\_\_\_\_

**GYNECOLOGIC:**

- a) When did your menstrual periods start? \_\_\_\_\_
- b) Date of last menstrual period? \_\_\_\_\_
- c) How many children have you had? \_\_\_\_\_
- d) Age of youngest child? \_\_\_\_\_
- e) Have you had any miscarriages? \_\_\_\_\_
- f) Are you taking birth control pills? \_\_\_\_\_

**NEUROPSYCHIATRIC:**

- a) Weaknesses \_\_\_\_\_
- b) Disease of nervous system \_\_\_\_\_
- c) Treatment for nervous or emotional problems \_\_\_\_\_

**ORTHOPEDIC: Do you have:**

- a) Disability \_\_\_\_\_
- b) Joint or neck pains \_\_\_\_\_
- c) Gout \_\_\_\_\_
- d) Arthritis \_\_\_\_\_