TEXAS UROLOGY SPECIALISTS

MRN: ______________

Urological Patient History Questionnaire

Today's Date: __________ Patient Name: ____ Date of Birth: ___________

Last First Middle or Maiden

Please answer the following questions:

Question	Response	Have you tried any medicine or treatment for this problem?
Any pain or burning when voiding/urinating?	☐ Yes ☐ No	☐ Yes ☐ No
Any urgency or need to run to the bathroom?	☐ Yes ☐ No	☐ Yes ☐ No
Any urinary frequency or need to void many times during the night?	☐ Yes ☐ No	☐ Yes ☐ No
Any sense of incomplete emptying of your bladder?	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage of urine?	☐ Yes ☐ No	☐ Yes ☐ No
Any blood in urine?	☐ Yes ☐ No	☐ Yes ☐ No
Any pain?	☐ Yes ☐ No	☐ Yes ☐ No
	If yes, where is your pain located? ____________________	

Is there any family history of the following diseases? If Yes, please indicate which family member has/had any of the following: (i.e. Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt, Etc.)

Disease or Condition	Family History	Family Member(s)
Adrenal Disease	☐ Yes ☐ No	
Bedwetting	☐ Yes ☐ No	
Bladder Cancer	☐ Yes ☐ No	
Crohn's Disease	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Gout	☐ Yes ☐ No	
Heart Attack	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No	
Hypertension	☐ Yes ☐ No	
Kidney Cancer	☐ Yes ☐ No	
Kidney Disease	☐ Yes ☐ No	
Kidney Stones	☐ Yes ☐ No	
Multiple Sclerosis	☐ Yes ☐ No	
Prostate Cancer	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Thyroid Disease	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No	

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Please return completed form to the appropriate physician's office.