

PLEASE BRING COMPLETED FORM WITH YOU FOR APPOINTMENT

AuSable Urology, P.C.

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**PATIENT'S MEDICAL HISTORY
Questionnaire**

(Please print or type)

Name _____ Date _____

Address _____

Street City State Zip

Sex _____ Age _____ Birthdate _____

Please give your physician's name _____ Physician's Phone _____

Address _____ (Including Zip)

Type of practice (for example, internist, family practice, etc.) _____

Were you referred by your physician? Yes No

Shall we send a report to your physician? Yes No

Marital Status Single _____ Married _____ Widowed _____ Divorced _____ Separated _____ Remarried _____

Circle last year of school 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Occupation _____ Working now? _____

If not, last worked _____ Are you disabled for work? _____

Spouse's Occupation _____

Number of Children _____ Ages _____

What is the chief problem that brings you to the clinic? _____

How long have you had the problem? _____

What do you think might be causing it? _____

PAST MEDICAL HISTORY

Hospitalizations

Year Diagnosis Operation (if any) Do Not Write In This Space

Other Serious Illnesses:

Year

Diagnosis

HISTORY: (list parents and all brothers and sisters)
(If dead, please list age at death and cause of death)

Living? Age

State of Health or Cause of Death

Mother _____

Father _____

Is there a family history for any of the following in a blood relative? (please check)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Migraine | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Nervous breakdown |
| <input type="checkbox"/> Kidney stones or failure | <input type="checkbox"/> Heart Attack before 60 | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Other Cancers | <input type="checkbox"/> Others _____ | |

MEDICINES: List all medications that you have been taking recently. (Please include all vitamins as well as prescribed medicine)

PLEASE BRING ALL MEDICATIONS WITH YOU

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

ALLERGIES: List all medications and other substances to which you are allergic.

IMMUNIZATIONS:

Pneumonia vaccine _____ (date) _____

Tetanus _____ (date) _____

X RAY STUDIES: Have you had any of the following x-ray studies (indicate the latest such study and result, if known)

Year

Results (if known)

Chest _____

Kidney _____

Stomach _____

Gallbladder _____

Large Bowel _____

Mammogram _____

Others _____

PERSONAL HABITS:

Tobacco? (type and amount per day) _____ If not smoking now, have you smoked in past _____

Alcohol? (amount per day or week) _____

Have you had a problem with alcohol? Yes No

Coffee, Tea and Cola Beverages? (cups per day) _____

Special Diet? _____

Do you have any of the following?	Yes	No	Do Not Write In This Space
1. Recent weight Gain (____ pounds)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Recent weight Loss (____ pounds)	<input type="checkbox"/>	<input type="checkbox"/>	
3. Fever or soaking sweats at night	<input type="checkbox"/>	<input type="checkbox"/>	
4. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you received an injury for which there is now a law suit pending?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Is the purpose of this examination to determine the existence or extent of a disability?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Treatment with X-rays?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Weakness or numbness of arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Headaches more than once or twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Difficulty walking?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Loss of consciousness or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Problem with vision that is not corrected with glasses?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Change in hearing?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Frequent or severe nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Trouble chewing or swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Sore tongue or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Neck pain or stiffness?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Daily cough?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Short of breath after walking up two flights of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	
21. Short of breath when just sitting or lying down?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Discomfort in the chest?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Swelling of the ankles every day?	<input type="checkbox"/>	<input type="checkbox"/>	
24. Pain in the legs while walking?	<input type="checkbox"/>	<input type="checkbox"/>	
25. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>	
27. Frequent heartburn or indigestion?	<input type="checkbox"/>	<input type="checkbox"/>	
28. Change in bowel habits?	<input type="checkbox"/>	<input type="checkbox"/>	
29. Black or bloody bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	
30. Bloody or otherwise unusual appearing urine?	<input type="checkbox"/>	<input type="checkbox"/>	
31. Difficulty urinating?	<input type="checkbox"/>	<input type="checkbox"/>	
32. Do you lose control of urine at times?	<input type="checkbox"/>	<input type="checkbox"/>	
33. Awaken at night more than once to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	
34. Any skin problems at this time?	<input type="checkbox"/>	<input type="checkbox"/>	

- | | | |
|--|--------------------------|--------------------------|
| 35. Persistent pain in joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Back pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 37. Do you enjoy your work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Frequent conflicts at home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Sexual problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you feel anxious or depressed much of the time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Have you seriously considered suicide? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Difficulty in sleeping? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. History of hospitalization for an emotional problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |

Women Only:

- | | | |
|--|--------------------------|--------------------------|
| 44. Are menstrual periods normal? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Date of last menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Any vaginal discharge? | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Any breast discharge? | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. Pregnancies ____ Deliveries ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. Bleeding between periods or after menopause? | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Approximate date of last PAP Smear? | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |

Have you ever had?

- | | | |
|--|--------------------------|--------------------------|
| a. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Gonorrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Hepatitis or Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Phlebitis | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Polio | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Syphilis | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Thyroid Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Ulcer | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Other Serious Illnesses Not Mentioned | | |

Please list below:

Signature of Patient