James G. Knight MD
Board Certified Urologist

Print Form

Today's Date:	**UROLOGY QUESTIONNAIRE** Please Complete Pages 1 And 2	Primary Care/ Referring Physician:

Last Name:	MI:	First Name:	Date Of Birth:

Circle the most appropriate answers

Are you allergic to any medication? ☐No ☐Yes….. If yes, please list all medication allergies:

Circle the most appropriate answers:

Did you or do you currently smoke cigarettes? ☐Yes ☐No	Quit? (yr) _____	Do you drink alcohol?	☐Yes ☐No
If Yes, please indicate for how many years?	years	If you do drink alcohol, how many drinks per day?	/day
If Yes, how many packs per day (ppd)?	ppd	What is your current weight?	pounds
Does your spouse or another family member smoke?	☐Yes ☐No	How tall are you?	____ft ____inches

Please check (✓) any current or prior Urological symptoms

BURNING OR PAIN ON URINATION ☐	URGENCY OF URINATION ☐	FREQUENCY OF URINATION ☐	FEVER ☐	BACK OR FLANK PAIN ☐
NAUSEA OR VOMITING ☐	PRIOR URINARY INFEC-TIONS ☐	RECENT BLADDER CATHETER ☐	PRIOR URETHRAL DILATIONS ☐	LEAKAGE OF URINE WITH STRAINING ☐
INABILITY TO EMPTY BLADDER ☐	DECREASE FORCE OF STREAM ☐	STRAINING TO URINATE ☐	DRIBBLING STREAM ☐	DECREASE SIZE OF STREAM ☐
PRIOR PROSTATE PROBLEMS (PROSTATITIS) ☐	FREQUENT URINATION AT NIGHT ☐	HESITANCY TO URINATE ☐	URETHRAL DISCHARGE ☐	PRIOR URETHRAL OR PROSTATE SURGERY ☐
BLOOD IN URINE ☐	PRIOR KIDNEY OR BLADDER STONES ☐	BLADDER OR PROSTATE CANCER ☐	SEXUALLY TRANSMITTED DISEASES ☐	DECREASE SEXUAL FUNCTION ☐

Please check (✓) any current or prior Medical problems

HEART ATTACK "INFARCTION" ☐	ABNORMAL HEART RHYTHM OR RATE ☐	ANGINA PECTORIS ☐	HEART FAILURE ☐	STROKE ☐	SEIZURE DISORDER ☐
PASSING OUT ☐	EMPHYSEMA ☐	ASTHMA ☐	PNEUMONIA ☐	EXCESSIVE BLEEDING ☐	TUBERCULOSIS ☐
ULCERS ☐	LIVER DISEASE ☐	INTESTINAL BLEEDING ☐	BLOOD VESSEL DISEASE ☐	BLOOD CLOT PROBLEMS ☐	DIABETES ☐
HIGH BLOOD PRESSURE ☐	PANCREATITIS ☐	HIATAL HERNIA ☐	THYROID DISEASE ☐	NEUROLOGICAL DISEASE ☐	ADRENAL DISEASE ☐
BACK INJURY ☐	CONGENITAL DISEASE ☐	JOINT DISEASE ☐	ARTHRITIS ☐	DIVERTICULITIS ☐	APPENDICITIS ☐
HEMORRHOIDS ☐	GONORRHEA ☐	SYPHILIS ☐	AIDS ☐	HERPES ☐	CONDYLOMA ☐
BREAST CANCER ☐	CERVICAL CANCER ☐	UTERINE CANCER ☐	OVARIAN CANCER ☐	LYMPHOMA ☐	LEUKEMIA ☐
LUNG CANCER ☐	COLON CANCER ☐	SKIN CANCER ☐	OTHER CANCER ☐	RADIATION ☐	CHEMOTHERAPY ☐

Please check (✓) any know family diseases

Diabetes ☐	Polycystic Kidneys ☐	Kidney Stones ☐	Kidney Cancer ☐
Prostate Cancer ☐	Kidney Failure/ Dialysis ☐	Bladder Cancer ☐	Other: ☐

COMPLETE BELOW WITH REGARD TO PRIOR SURGICAL PROCEDURES

TYPE OF SURGERY	**APPROXIMATE DATE(S) OF SURGERY**
HEART	
LUNG	
ULCER	
COLON	
KIDNEY	
PROSTATE	
BLADDER	
GALLBLADDER	
APPENDIX	
HERNIA (RIGHT, LEFT, BOTH)	
VASECTOMY	
MAJOR BLOOD VESSEL SURGERY	

TYPE OF SURGERY	**APPROXIMATE DATE(S) OF SURGERY**
JOINT REPLACEMENT	
HEMORRHOIDS	
URINARY INCONTINENCE	
OVARY	
HYSTERECTOMY	
CESARIAN SECTION(S)	
VAGINAL BIRTH(S)	
TUBAL LIGATION	
EYE	
OTHER PROSTHETIC IMPLNANTS	
OTHER	

DO YOU TAKE ANY MEDICATION ON A REGULAR BASIS? (YES OR NO)

IF **YES**, PLEASE COMPLETE THE FOLLOWING.

NAME OF MEDICATION	DOSAGE (MG,GRAM ETC.)	NUMBER OF TIMES TAKEN DAILY

IS THERE ANY ADDITIONAL INFORMATION NOT PREVIOUSLY COVERED?

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND CORRECT.

Signed _____ Date: _____

4/16/2006 10:54:00 AM