Cooper Urologic Institute
Patient Questionnaire

Welcome to the office of Cooper Urologic Institute of Cooper University Hospital. Please take a few minutes to answer the following questions before your office visit. This will allow us to get to know you better, accurately assess your problem and provide you with the best care possible. Bring this completed form to your visit. **Please print clearly.**

Patients Name	**Date of Birth**	**Age**	**Today's Date**
Referring Physician	**Physician's Address**		**Physician's Phone #**

Are there any other physicians you would like to receive reports of your visits? Y / N

Physician	Address	Phone

Chief Complaint (Please describe the reason you are seeing the doctor today)

_____
_____
_____
_____

Are you currently taking any medications? _____ Yes _____ No
If so, please list all **MEDICATIONS** that you are taking and include the **DOSE** if possible.

Medication	Dose	Medication	Dose

Are you allergic to any Medications? _____Yes _____No
If so, please list the **MEDICATION** and your **REACTION**:

Medicine	Reaction

Do you have any Other Allergies, such as dyes, soaps, latex, food, etc. _____Yes _____ No	
Allergen	Reaction

Attending signature line indicating review:
Signature:_____ Date:_____ Signature:_____Date:_____
Signature:_____Date:_____ Signature:_____Date:_____
Signature:_____Date:_____ Signature:_____Date:_____

Patient Name: _____ Date: _____

Do you take medications such as Aspirin, Motrin, Advil, Nuprin, etc. on a regular basis? Y / N If yes, please list type, frequency and reason:		
Type	Frequency	Reason

Past Medical History

Please list any **Surgeries** you may have had and the approximate date:	
Surgery	Date

If you have ever been **Hospitalized**, except for the surgeries listed above, please list:		
Date	Reason	Hospital

Please list any **Medical Conditions** that you have been diagnosed with:			
Diagnosis	Date	Diagnosis	Date

Past Family History

Please list any conditions that any immediate family members have been diagnosed with, any deaths, age at death and reason for the death		
Family Member	Diagnosis / Death	Date / Age
Mother		
Father		
Sister / Brother		
Sister / Brother		
Maternal Grandparents		
Paternal Grandparents		

Patient Name: _____ Date: _____

Past Social History

Do you drink alcohol? _____ Yes _____ No
If yes, please list the amount and frequency: _____

Do you use tobacco? _____ Yes _____ No
If yes, please circle the type and fill in the frequency:
Cigarettes/ pipe/ cigar/ chewing tobacco _____ per day/ week/ month
If you have quit, please indicate (using above selections) frequency and list how long ago you quit: _____

Do you take any non-prescription medication (1.e. illegal or illicit drugs)?
_____ Yes _____ No
If yes please list the type of drug, amount and frequency _____

Review of Systems

Please check any symptoms that you are currently experiencing and use space provided to briefly explain: Please write Y / N

Symptoms

Fatigue	_____	Frequent Urination	_____
Excessive Thirst	_____	Menstrual Disturbances	_____
Unexplained Fevers	_____	Muscle Weakness	_____
Hair Loss	_____	Acne	_____
Unwanted Hair Growth	_____	Breast Discharge	_____
Vision Changes	_____	Skin Changes or Ulcers	_____
Chest Pain	_____	Extremity Numbness	_____
Dizziness	_____	Extremity Tingling	_____
Palpitations	_____	Headaches	_____
Breathing Difficulties	_____	Weight Gain	_____
Abdominal Pain	_____	Weight Loss	_____
Bloating Flatulence	_____	Other Sexual Difficulties	_____
Nausea/Vomiting	_____	Change or Lack of Sexual Desire	_____
Constipation	_____	Night Sweats	_____
Diarrhea	_____		

Explanation: _____
_____
_____