Asheville Urological Associates, Inc.

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Diplomates of the American Board of Urology
Dr. Bruce Armstrong
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Dr. James Brien

AUA Admin.
Account #_____

Patient Questionnaire

Date: ___/___/___ Patient Name: _____ Date of Birth: ___/___/___ Age: _____

1. What is the main reason you are seeing the doctor today? _____

   _____

2. Was this consultation requested by a Physician? ☐ Yes ☐ No

   If so, by whom? _____

3. Have you seen a Urologist before? ☐ Yes ☐ No

   If so, which Urologist have you seen? _____

4. What pharmacy do you prefer to use? Name _____

   Address_____ Phone_____

5. Please list any medications that you are ALLERGIC to: ☐ **No Known Drug Allergies**

6. List the Names (and Dose, if known)of any prescription or over the counter medications you take

   If you have a medication list, please give it to the medical staff

   ☐ **No Medications**

Medications	Strength	Times taken per day

7. Do you take any of the following blood thinners? (Check those that apply) ☐ **No Blood Thinners**

   ☐ Aspirin ☐ Coumadin/Warfarin ☐ NSAIDS
   ☐ Plavix ☐ Xarelto ☐ Pradaxa
   ☐ Other _____

Patient Name: _____ Date of Birth: ___/___/___ Age: _____

Patient Questionnaire Continued

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8. Please list all operations you have ever had (if known, list the date). ☐ **No Operations**

9. Please list ALL medical problems (check all that apply) ☐ **No Medical Problems**

☐ Blood Pressure – High or Low (circle one) ☐ High Cholesterol ☐ Diabetes – Type I or Type II (circle one)
☐ Thyroid - High or Low (circle one) ☐ COPD ☐ Heart Disease

Please list any additional medical problems

10. Do you leak urine? ☐ **Yes** ☐ **No**

11. Do you have a family history of any of the following? Place a ☑ in all boxes that apply.

	Father	Mother	Brother	Sister	Children
Bladder Cancer					
Kidney Stones					
Prostate Cancer					
Colon Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Kidney Cancer					
Kidney Dialysis					
Lung Cancer					

☐ **Family History Unknown**

12. What is your occupation? _____

13. Do you smoke? ☐ Current Every day Smoker ☐ Current Some Day Smoker ☐ Former Smoker
☐ Never Smoked Packs smoked per day_____

Smoking Duration: ☐ 1-5 years ☐ 6-10 years ☐ 11-20 years ☐ over 20 years

Smokeless Tobacco ☐ Yes ☐ No

14. How many caffeinated drinks do you have each day? _____

15. Do you drink alcohol? ☐ Yes ☐ No ☐ Former How much? _____

16. How much do you weigh? _____ How tall are you? _____ft _____inches

Patient Name: _____ Date of Birth: ___/___/___ Age: _____

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Patient Questionnaire Continued

17. Have you ever had a serious problem or been treated for any of the following?
(Please check *Yes* or *No* for each symptom

Constitutional Symptoms	Yes	No
Change in appetite		
Weight Change		
Chills		
Fever		

Eyes		
Glaucoma		
Cataracts		

ENT		
Nose Bleed		
Difficulty Swallowing		
Hoarseness		
Hearing Loss		

Respiratory		
Shortness of Breath		
Cough		
Coughing up Blood		

Cardiac		
Chest Pain		
Heart Attack		
Palpitations		
High Blood Pressure		

GI		
Abdominal Pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		

Musculoskeletal		
Arthritis		
Joint Pain		
Joint Replacement		
Back Pain		

Neurological	Yes	No
Dizziness		
Seizure		
Headache		
Loss of Consciousness		

Skin		
Rashes		
Non-Healing Lesions		

Psychiatric		
Nervousness		
Mood Changes		
Depression		

Endocrine		
Thyroid Trouble		
Diabetes		

Hematology		
Anemia		
Easy Bruising		
Swollen Glands		

Genito-Urinary		
Kidney Disease		
Kidney Stones		
Bladder Trouble		
Blood in Urine		
Urinary Infection		
Prostate Gland		
Urinary Incontinence		
Urinary Frequency		