

# Seattle Prostate Institute New Patient Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's date \_\_\_\_\_

## **MEDICAL HISTORY**

Previous cancer	Y / N	Stroke	Y / N	Crohn's disease or Ulcerative colitis	Y / N
High blood pressure	Y / N	Emphysema/COPD	Y / N	Kidney loss, dysfunction or abnormality	Y / N
Heart attack	Y / N	Diabetes	Y / N	Lupus/Scleroderma/Collagen vascular disease	Y / N
Pacemaker	Y / N	Diverticulitis	Y / N	Rheumatoid/Psoriatic Arthritis	Y / N
Defibrillator	Y / N	HIV	Y / N		

Previous radiation therapy Y / N If yes, to what part of the body? \_\_\_\_\_

Facility name \_\_\_\_\_ Dates \_\_\_\_\_

### Previous surgeries:

Type of Operation	Approximate Date	Type of Operation	Approximate Date
_____	_____	_____	_____
_____	_____	_____	_____

Other illnesses/hospitalizations \_\_\_\_\_

Prostate Surgery (Transurethral resection of prostate "TURP") Y / N If yes, when? \_\_\_\_\_

Prostate Biopsy Y / N If yes, when? \_\_\_\_\_ Date of last colonoscopy \_\_\_\_\_

## **MEDICATIONS/SUPPLEMENTS** (List **ALL** medications, vitamins, supplements & over the counter drugs you are taking)

Medication	Dose	Dose/day	Medication	Dose	Dose/day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## **MEDICATION ALLERGIES** \_\_\_\_\_ None

Medication \_\_\_\_\_ Reaction \_\_\_\_\_

Medication \_\_\_\_\_ Reaction \_\_\_\_\_

## **FAMILY HISTORY OF CANCER**

Type/location of cancer	Age at diagnosis	Type/location of cancer	Age at diagnosis
Father _____	_____	Brother/sister _____	_____
Mother _____	_____	Brother/sister _____	_____

## **SOCIAL HISTORY**

Do you drink alcohol Y / N If yes, average number of drinks per day \_\_\_\_\_

Have you ever smoked cigarettes Y / N If yes, year you began smoking \_\_\_\_\_ Year stopped \_\_\_\_\_

Average # of packs smoked per day \_\_\_\_\_ List other tobacco products used \_\_\_\_\_

Current occupation \_\_\_\_\_ # years \_\_\_\_\_

Previous occupation \_\_\_\_\_ # years \_\_\_\_\_

## **REVIEW OF SYSTEMS**

Have you developed any of these symptoms in the past year?

Weight loss	Y / N	Fatigue	Y / N	Cough	Y / N	Weakness	Y / N
Decreased appetite	Y / N	Fever	Y / N	Short of breath	Y / N	Numbness/Tingling	Y / N
Nausea	Y / N	Bone pain	Y / N	Chest pain	Y / N	Memory problems	Y / N
Diarrhea	Y / N	Skin rashes	Y / N	Depression	Y / N	Vision/Hearing changes	Y / N
Bleeding problems	Y / N	Swollen glands	Y / N	Headaches	Y / N	Change in urination	Y / N

I attest that all statements on this form are true and correct x \_\_\_\_\_

(Patient signature)

Reviewing Physician Signature \_\_\_\_\_ Date \_\_\_\_\_