

Medical Questionnaire

The following questionnaire is designed to help your physician evaluate you. If you have any additional information or comments you may write them in the additional space provided.

Date: _____

Patient's Name: _____

Age _____

Spouse/Parent: _____

Age _____

Occupation: Patient: _____

Spouse/Parent: _____

What is the reason for today's visit?

Medical History

Do you have any medical problems?

If yes, please explain:

Do you take any medications?

If yes, please list:

Are you allergic to any medications, foods or latex?

If yes, please list:

Do you have or have you ever had problems with:

Chronic respiratory infections

Loss of sense of smell

Infections

Have you had any previous infections of the following?

(If yes, please describe treatment and give dates)

*Kidneys

*Prostate

*Testicles

*Epididymis

*Urethra

Have you had exposure in the last six months to any of the following?

*Pesticides

*Chemotherapy

*Anabolic steroids

*High temperatures

*Radiation treatment

Surgical History

Have you had any previous operations?

If yes, please list.

Social History

Do you currently consume alcohol?

If yes, how much per week?

Do you presently use:

*Cigarettes

*Any recreational drugs

If yes, amount per day:

Do you presently use herbal agents?

If yes, please list.

Childhood

As a child did you have any of the following?

*Undescended testicles?

If yes, what side?

Was it corrected with surgery?

*Testicular torsion?

*Hernia surgery?

If yes what side?

*Mumps?

If yes, did it involve the testicles?

Did it occur after puberty?

*Bladder surgery?

*Hypospadias surgery?

Family History

How many brothers do you have?

Sisters?

Does anyone in your family have a history of?

*Infertility?

*Cystic Fibrosis?

*Hormone imbalance?