

**PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE**

**• WHERE is your problem?**

Abdomen / Back / Genitals / Other

Describe: \_\_\_\_\_



**• Do you have any PAIN?**

YES NO (If NO skip the next question)

**• What KIND of pain do you have? Sharp / Dull / Throbbing / Achy / Pressure / Cramping / Crushing / Vague**

Describe: \_\_\_\_\_

**• On a scale of 1-10, (10 is the most severe) circle the number that best describes the SEVERITY of your problem or your pain.**

(no problem) 1 2 3 4 5 6 7 8 9 10 (most severe)

**• When did you FIRST NOTICE the problem? (When did it start?)**

How many (circle one) days / weeks / month(s) ago: \_\_\_\_\_

**• HOW LONG does each episode last?**

Seconds / Minutes / Hours / Days / Always there

Describe: \_\_\_\_\_

**• WHEN does this problem happen?**

Daytime / Nighttime / When you are active / Unpredictable

Describe: \_\_\_\_\_

**• HOW OFTEN are you having the problem or the pain?**

Describe: \_\_\_\_\_

**• What HELPS or what makes the problem WORSE?**

Describe: \_\_\_\_\_

**• Are any OTHER SYMPTOMS occurring at the same time?**

Describe: \_\_\_\_\_

**• List all of your current health conditions, and list all hospitalizations and surgeries you have had:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**• List all medications you take regularly:**

\_\_\_\_\_  
 \_\_\_\_\_

**• List all medication allergies:**

\_\_\_\_\_  
 \_\_\_\_\_

**• Do you smoke? No Yes How Much?**

\_\_\_\_\_  
 \_\_\_\_\_

**• Do you use drugs or alcohol? No Yes How Much?**

\_\_\_\_\_  
 \_\_\_\_\_

**• What is/was your occupation? (What did you retire from?)**

\_\_\_\_\_  
 \_\_\_\_\_

**• What is your current marital status?**

Single / Varied / Separated / Divorced / Widowed

**• List all serious illnesses in your family, including parents, grandparents and siblings. (Diabetes, any kind of cancer, high blood pressure, heart disease, kidney disease or stones, thyroid disease, etc.)**

**Mother:**

Maternal GM: \_\_\_\_\_

Maternal GF: \_\_\_\_\_

**Father:**

Paternal GM: \_\_\_\_\_

Paternal GF: \_\_\_\_\_

**Bro./Sis.:**

\_\_\_\_\_  
 \_\_\_\_\_

**• Do you have any of the following problems TODAY? Please mark YES (Y) or NO (N) for EACH item below.**

Y N Kidney disease	Y N Fever	Y N Wheezing	Y N Back pain	Y N Easy bruising
Y N Bloody urine	Y N Chills	Y N Frequent cough	Y N Headaches	Y N Seasonal allergies
Y N Painful urination	Y N Change in Weight	Y N Short of breath	Y N Tremors	Y N Other health problems
Y N Urinary hesitancy	Y N Change in appetite	Y N Abdominal pain	Y N Numbness or tingling	
Y N Urinary retention	Y N Blurred/double vision	Y N Nausea	Y N Dizzy Spells	
Y N Urinary frequency	Y N Eye pain	Y N Vomiting	Y N Anxiety	
Y N Urinary urgency	Y N GER pain	Y N Indigestion	Y N Depression	
Y N Urinary incontinence	Y N Hearing loss	Y N Heartburn	Y N Insomnia	
Y N Nighttime urinations	Y N Sinus problems	Y N Skin problems	Y N Excessive thirst	
How many? _____	Y N Sore throat	Y N Skin cancer	Y N Intolerant to heat/cold	
GATE last period Started?	Y N Chest pain	Y N Joint pain	Y N Tired or fatigued	
	Y N Varicose veins	Y N Neck pain	Y N Swollen glands	