GARO M. TERTZAKIAN, M.D., F.A.C.S

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UROLOGY

PATIENT QUESTIONNAIRE

Date: _____

Name: _____

Birth Date: _____ Age: _____

Primary Doctor Name and Number: _____

_____

What is the urological reason for your appointment today?

_____

_____

_____

Preferred pharmacy name/number/city

_____

_____

List of medications you are currently on with dosage and directions?

1. _____ 5. _____ 9. _____

2. _____ 6. _____ 10. _____

3. _____ 7. _____ 11. _____

4. _____ 8. _____ 12. _____

List any allergies your may have? (Include food allergies)

1. _____ 2. _____ 3. _____

Please indicate all surgeries you had (with approximate year of the surgery:

Aortic Aneurysm: Date:	Thyroid Surgery: Date:	Heart Surgery: Date:	Heart Angioplasty stent: Date:
Cholecystectomy/Gallbladder: Date:	Hernia Repair: Date:	Appendix: Date:	Tonsillectomy: Date:
Cataract surgery/eye surgery: Date:	Colon Resection Date:	C-Section: Date:	Coronary Artery Bypass Date:

Back surgery or Neck surgery: Date:	Hysterectomy/bladder/ pelvic surgery: Date:	Heart Pacemaker: Date:	Hemorrhoid Surgery: Date:
Mastectomy/Breast cancer surgery: Date:	Weight loss surgery: Date:	Hip or Knee replacement: Date:	Other:

Check any of the following conditions which you have now:

Thyroid Problems:	Diabetes:	Rheumatoid Arthritis:	Tuberculosis:
Stomach Ulcers:	Heart Disease:	Kidney Problems:	Fibromyalgia:
High/low Blood Pressure:	Cancer/Type:	Stroke:	Liver Disease:
Anxiety or depression:	Congestive Heart Failure:	Peripheral Vascular Disease:	Asthma:
Diverticulosis:	Sleep Apnea:	Hypercholesterolemia/high cholesterol:	Chest pain/Angina:
Arthritis:	GERD/reflux:	Gout:	

Any other medical conditions:

1. _____ 2._____ 3._____

4._____ 5._____ 6._____

Family medical history

Prostate cancer:	Kidney cancer:	Bladder Cancer:	Kidney Stones:	Diabetes

Family History of other Diseases:

1. _____ 2._____ 3._____

Marital Status:

Married _____Single _____Divorce_____Widowed _____Separated _____

Do you have any children? **Yes / No** If yes, how many? _____Ages? _____

Do you smoke? **YES / NO** Cigarettes per day: _____ For how long?_____

Do you drink alcohol beverages? **YES/NO**

How often: _____For how long? _____

Have you ever done any street drugs? **Yes / No**

If yes, what kind and how long ago? _____

Have you ever been in an alcohol or drug rehabilitation program? **Yes / No**

Race (not mandatory, requested by government)

American Indian/Alaska Native/ _____Black/African American _____ Hawaiian/Pacific islander ___White _____

Ethnicity (not mandatory, requested by government)

Not Hispanic or Latino _____Hispanic or Latino ____Decline to state _____

Preferred language:_____

Do you have any of the following symptoms?

Fever	Chills	Weight Loss	Blurry vision
Double Vision	Cataracts	Hearing Loss	Nasal Stuffiness
Sore Throat	Chest Pains	Swollen Ankles	Irregular Heartbeat
Shortness Pain	Nausea/Vomiting	Change in Bowels	Incontinence
Painful Urination	Blood in Urine	Chronic Back Pain	Chronic Next Pain
Sore Muscles	Rash	Persistent itching	Skin Cancer History
Numbness	Tingling	Dizziness	Swollen Glands
Abnormal Bleeding	Transfusion History		

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Questions for female patients only

1. When was your last menstrual period?_____are they normal? **Yes / No**

If no describe: _____

2. Number of pregnancies, _____# of live births? _____ 3. Were they delivered vaginally? ( ) via C-section? ( ).

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PATIENT INITIALS:_____DATE_____

GARO M. TERTZAKIAN, M. D.

Male and Female Urology, Minimally Invasive Urologic Surgery

Please print

Patient's Name: _____: Date: _____/_____/_____

SSN: _____ MALE ( ) FEMALE ( )

Home Address: _____ Home Phone: (____)_____:

City _____State _____Zip code _____ CELL#: (____)_____:

How long at this address? _____ E-mail_____

DATE OF BIRTH: _____; Married _____Single _____Divorce_____Other _____

RELATIVE OR FRIEND TO CALL IN CASE YOU CAN'T BE REACHED.

NAME_____PHONE; _____

EMPLOYER INFORMATION;

COMPANY NAME: _____:

ADDRESS: _____:

CITY: _____: STATE: _____: ZIP CODE: _____

PHONE; _____; JOB DESCRIPTION:_____

INSURANCE INFORMATION:

NAME OF INSURED: _____

INSURANCE NAME: _____Policy Number_____.

ADDRESS: _____

PHONE: _____; Group Number:_____

I hereby authorized Garo M. Tertzakian, M.D. to furnish relevant information to insurance carriers concerning this medical condition and I assign to the doctor all payments and all major benefits for medial and surgical services renderd.

PATIENT'S SIGNATURE; _____DATE: _____: