John J. Bauer, M.D., F.A.C.S.
www.flinturology.com

Urology Services, Inc.
G-1121 West Hill Rd.
Flint, Michigan 48507
Tel: 810.232.8888
Fax: 810.232.9190
Email: jbauer@flinturology.com

Follow-Up Visit Questionnaire

REGISTRATION DATA:

Since your last visit to this office, have you:

changed names?	Yes_____	No_____
moved?	Yes_____	No_____
changed contact numbers?	Yes_____	No_____
changed jobs?	Yes_____	No_____
changed insurance company?	Yes_____	No_____
changed doctors?	Yes_____	No_____
changed pharmacy	Yes_____	No_____
changed lab	Yes_____	No_____

Do you want to change the contact for emergencies encountered during the office visit?
Yes_____ No_____ If yes please provide new contact _____.

If you answered yes to any of these questions please provide the new information below.

HISTORY DATA:

Since your last visit to this office, has your/ have you:

Been admitted to a hospital?	Yes_____	No_____
Gone to an emergency room?	Yes_____	No_____
Changed your medications?	Yes_____	No_____
Received any surgery?	Yes_____	No_____
Has your overall health become worse?	Yes_____	No_____
New medical problems or disease diagnosis?	Yes_____	No_____
Your allergies changed?	Yes_____	No_____

Has your medical condition that you saw our practice for on your last visit changed?
Yes_____ No_____ If yes, please explain in your own word how it has changed?

Are you seeing us for the same problem? Yes_____ No_____
If no, please explain your new problem below.

For Males Only:
Have your male sexuality issues changed? Yes_____ No_____
Have you had a more recent PSA test? Yes_____ No_____
If yes, provide value and date: _____

For Females Only:
Have you had any additional children? Yes_____ No_____
Any recent miscarriages? Yes_____ No_____
Any new female organ problems? Yes_____ No_____
Any new female sexuality issues? Yes_____ No_____
Do you now leak urine? Yes_____ No_____

When was your last menstrual period? _____

******COULD YOU BE PREGNANT AT THIS TIME? Yes_____ No_____**

REVIEW OF SYSTEMS:

Do you have any other general systemic symptoms such as:
Fever and/or chills? Yes_____ No_____
Nausea or vomiting? Yes_____ No_____
Diarrhea? Yes_____ No_____
Constipation? Yes_____ No_____
Headache? Yes_____ No_____
Weight loss? Yes_____ No_____
Night sweats? Yes_____ No_____
New onset bone pain? Yes_____ No_____
Recent chest pain? Yes_____ No_____
Recent episode of shortness of breath? Yes_____ No_____

Head, ears, nose and throat problems? Yes_____ No_____
Any lumps in your neck? Yes_____ No_____
Frequent infections? Yes_____ No_____
Any eyesight problems? Yes_____ No_____
Any hearing problem? Yes_____ No_____
Any dizziness? Yes_____ No_____

Any problems with your lungs or breathing? Yes_____ No_____

- Shortness of breath? Yes_____ No_____
- Asthma? Yes_____ No_____
- Wheezing? Yes_____ No_____
- Gurgling sounds? Yes_____ No_____
- Ever cough up blood? Yes_____ No_____
- Ever have pneumonia? Yes_____ No_____
- Any others? Yes_____ No_____
  - Explain:

Any problems with your heart? Yes_____ No_____

- Any heart attacks? Yes_____ No_____
  - How many and when? _____
- Any chest pain/angina? Yes_____ No_____
- Chest Pain with exertion? Yes_____ No_____
- Indigestion? Yes_____ No_____
- Heartburn? Yes_____ No_____
- Radiation of pain to neck or arms? Yes_____ No_____

Any problems with your gastrointestinal system? Yes_____ No_____

- Nausea, vomiting? Yes_____ No_____
- Diarrhea, constipation? Yes_____ No_____
- Rectal bleeding? Yes_____ No_____
- Vomit coffee grounds? Yes_____ No_____
- Blood in toilet after BM? Yes_____ No_____
- Ulcers? Yes_____ No_____
- Gastritis? Yes_____ No_____
- Heartburn? Yes_____ No_____
- Acid reflux? Yes_____ No_____

Any problems with your male or female organs? Yes_____ No_____

Any problems with your muscles or joints? Yes_____ No_____

Any problems with your brain or neurological system? Yes_____ No_____

Any vascular problems? Yes_____ No_____

- Pain in extremities with activity? Yes_____ No_____
- Varicose veins? Yes_____ No_____

IF THERE IS ANYTHING ELSE IN YOUR MEDICAL HISTORY THAT YOU THINK YOUR DOCTOR SHOULD BE AWARE OF NOT INCLUDED ABOVE PLEASE LIST IT HERE:

I read the above questionnaire and this information is true to the best of my knowledge.

Patient Signature: _____ Date: _____