

Personal Health Questionnaire

- 1) Name: _____
- 2) Date of Birth: ____ day ____ month _____ year
- 3) Height: ____ feet ____ inches
- 4) Weight: _____
- 5) Past Medical History (Other Medical Problems): ____ yes ____ no
If yes, please explain: _____

- 6) Prior Surgery: _____ Date: _____
- 7) Medications (Include Dose) – Please list:
 - a. _____
 - b. _____
 - c. _____
- 8) Allergies to Medications: _____
- 9) Do you smoke? ____ yes ____ no If So, how many packs per day? _____
- 10) When did you quit smoking? _____
- 11) Are your parents alive? ____ yes ____ no
- 12) Age of death of mother and cause of death: _____
- 13) Age of death of Father and cause of death: _____
- 14) Any family history of prostate cancer? _____
- 15) Occupation/Job? _____
- 16) How many children do you have? _____
- 17) Who referred you to Dr. Scherr? _____
- 18) Name of Medical Insurance Primary: _____
- 19) Name of Medical Insurance Secondary: _____