New Patient Intake Form | Demographic Information

Patient Name (please print): _____ D.O.B. _____/_____/_____

Patient Phone: H: (____)_____-_____ M: (____)_____-_____ Preferred Contact: ☐ H ☐ M

Email Address: _____ SSN: ____-___-_____ Sex: ☐ F ☐ M

Marital Status: ☐ M ☐ S ☐ W ☐ D | Children: ☐ Y ☐ N # _____ | Ethnicity: ☐ Asian

☐ Black/African American ☐ Hispanic/Latino ☐ White/Not Hispanic ☐ Other Race

☐ Am. Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Decline to Specify

Do you have an Advanced Directive/Living Will/Healthcare Surrogate? ☐ Yes ☐ No

Permanent Address:	Seasonal Address (Include Dates):	Mailing Address:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referring Physician _____ Primary Care Physician _____

Emergency Contact Name: _____ Phone: (____)_____-_____ Relationship: _____

Urology Partners
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New Patient Intake Form
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Allergies

(Please include medication allergies, environmental allergies & food allergies)

Allergies	Reaction(s)	Mild, Moderate or Severe

Please check here if a list of additionally allergies have been attached: ☐

Family Medical History

	Mother	Father	Sister	Brother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Age / Deceased								
Prostate Cancer								
Kidney Cancer								
Bladder Cancer								
Colon Cancer								
Other Cancer(s)								
Kidney Failure								
Kidney or Bladder Stones								
Polycystic Kidneys								
Urinary Tract Infections								
Interstitial Cystitis								
Diabetes (Type I or II)								
Cardiovascular Disease								

Social History

Tobacco Use:

Are you a: ☐ Current tobacco user, ☐ Former tobacco user, ☐ Non-tobacco user, ☐Uses tobacco in other forms; specify: _____

If you are a current tobacco user how long have you used tobacco? _____ If you are a former tobacco user when did you quit? _____

How often do you smoke? ☐ Daily ☐ Sometimes How many cigarettes a day do you smoke? ☐ 1ppd ☐ ½ppd ☐Less than ½ ppd

Second hand smoke exposure? ☐ Yes ☐ No If yes, please note: ☐ Frequently ☐ Sometimes ☐ Rarely

Patient Name: _____ D.O.B: ____/____/____

Social History Continued

Alcohol Use:

Do you consume Alcohol? ☐ Y ☐ N What type of alcohol do you drink? ☐ Beer ☐ Wine ☐ Liquor

If yes, how often do you drink? ☐ Daily ☐ Weekly ☐ Socially ☐ Occasionally

Sexual History:

Are you sexually active? ☐ Y ☐ N

Do you currently have or do you have a history of a sexually transmitted infection? ☐ Y ☐ N

If yes, please specify: ☐ HPV ☐ Herpes ☐ HIV/AIDS ☐ Hepatitis (A / B / C) ☐ Gonorrhea ☐ Chlamydia

Other:

Exercise Habits: ☐ Daily ☐ Weekly ☐ Monthly | Dietary Habits: ☐ Specific Diet ☐ Overall Healthy ☐ None

Caffeine Habits: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Do you take blood thinners? ☐ Y ☐ N If yes, specify (med./dose/freq.): _____

Review of Systems

(In the last six months, have you experienced any of the following symptoms?)

Constitutional
- ☐ Easy Bruising
- ☐ Change in Appetite
- ☐ Chills/Night Sweats
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss/Gain

Allergies
- ☐ Animal
- ☐ Environmental
- ☐ Food
- ☐ Seasonal

Eyes
- ☐ Double Vision
- ☐ Changes in Vision
- ☐ Blurred Vision
- ☐ Eye Pain
- ☐ Itching/Redness

Ears/Nose/Throat/Mouth
- ☐ Hearing Loss
- ☐ Sinus Infections
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Ringing/Painful Ears

Endocrine
- ☐ Tired/Sluggish
- ☐ Decreased Libido
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Heat Intolerance

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular
- ☐ Swollen Extremities
- ☐ Painful Extremities
- ☐ Chest Pain
- ☐ Palpitations

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion/Heartburn
- ☐ Nausea/Vomiting

Hematologic
- ☐ Blood Clots
- ☐ Bleeding Problems
- ☐ Recent Transfusion
- ☐ Swollen Glands

Genitourinary
- ☐ Weak Stream
- ☐ Awaken to Urinate
- ☐ Leaking of Urine
- ☐ Burning Urination
- ☐ Urgent Urination
- ☐ Not Emptying Bladder
- ☐ Blood in Urine

Musculoskeletal
- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Joint Pain/Stiffness
- ☐ Muscle Cramps/Aches
- ☐ Sciatica
- ☐ Swollen Joints

Skin
- ☐ Pigment Changes
- ☐ Changing Moles
- ☐ Open Wound(s)
- ☐ Change in Hair/Nails
- ☐ Rash/Hives/Itching

Neurologic
- ☐ Migraines
- ☐ Fainting/Lightheadedness
- ☐ Memory Loss

Psychiatric
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety

Women Only
- ☐ Prolapse of Bladder
- ☐ Painful Intercourse
- ☐ Vaginal Pain/Discharge

Men Only
- ☐ Difficulty w/ Erections
- ☐ Genital Pain/Swelling
- ☐ Penile Discharge

Patient Name: _____ D.O.B: ____/____/____

Medications

Medication Name	Dosage	Frequency

Please check here if medication list has been attached: ☐ Please list preferred Pharmacy: _____

Surgical History

(Please provide exact dates for surgical procedures, if known. If not please provide an approximation.)

☐ Skin Cancer Removal	____/_____	☐ Colon Resection	____/_____	☐ Gall Bladder	____/_____
☐ Appendectomy	____/_____	☐ PPM/ICD Implant	____/_____	☐ Cardiac Stent	____/_____
☐ Thyroid	____/_____	☐ Lung Surgery	____/_____	☐ Hernia (Ing/Abd)	____/_____
☐ Hip (Right/Left)	____/_____	☐ Knee (Right/Left)	____/_____	☐ Back (C/T/L/S)	____/_____
☐ Hysterectomy	____/_____	☐ Kidney Stone Removal	____/_____	☐ Bladder Sling	____/_____
☐ Prostatectomy	____/_____	☐ Nephrectomy (R/L)	____/_____		

☐ Other: _____

Past Medical History

(Please answer the following questions below about your personal <u>past</u> medical history.)

Cardiovascular

☐ Heart Attack	☐ High Blood Pressure	☐ High Cholesterol	☐ Heart Valve Problems	☐ Irregular Heartbeat
☐ Heart Murmur	☐ Deep Vein Thrombosis	☐ Anemia	☐ Bleeding Tendency	☐ Congestive Heart Failure

Endocrine

☐ Diabetes	☐ Hyperthyroid	☐ Hypothyroid	☐ Gout

GI

☐ Acid Reflux	☐ Irritable Bowels	☐ Peptic Ulcers	☐ Diverticulitis	☐ Diverticulosis
☐ Crohn's	☐ Colitis	☐ Gallstones	☐ Constipation	☐ Diarrhea

GU

☐ Kidney Stones	☐ Bladder Stones	☐ Recurrent UTIs	☐ BPH	☐ Prostatitis
☐ Hematuria	☐ Erectile Dysfunction	☐ Elevated PSA	☐ Incontinence	☐ Overactive Bladder
☐ Hypogonadism	☐ Interstitial Cystitis	☐ Kidney Disease	☐ Other: _____	

EENT

☐ Glaucoma	☐ Cataracts	☐ Vertigo	☐ Chronic Ear Infection

Musculoskeletal

☐ Arthritis	☐ Chronic Back Pain	☐ Chronic Joint Pain	☐ Fibromyalgia

Neurologic

☐ Stroke	☐ Chronic Headaches	☐ Parkinson's	☐ Multiple Sclerosis	☐ Seizures
☐ Polio	☐ Alzheimer's/Dementia	☐ Spinal Cord Injury	☐ Spina bifida	

Pulmonary

☐ Emphysema	☐ Asthma	☐ Bronchitis	☐ COPD

Hematology/Oncology

☐ Prostate Cancer	☐ Bladder Cancer	☐ Kidney Cancer	☐ Testicular Cancer	☐ Uterine Cancer
☐ Ovarian Cancer	☐ Colorectal Cancer	☐ Lung Cancer	☐ Leukemia	☐ Lymphoma
☐ Skin Cancer	☐ Other: _____			