NEW PATIENT INTAKE

FIRST NAME: _____ **LAST NAME:** _____ **DOB:** _____

POA/LEGAL SIGNER (if not patient): _____ **PHONE**: _____

REFERRED BY: _____ **PRIMARY CARE DOCTOR:** _____

PHARMACY: (Name, Address/Phone)_____

ALLERGIES: ☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/Contrast ☐ Other:_____

MEDICAL HISTORY: Height: _____ Weight: _____

Influenza Vaccine Date: _____ Pneumonia Vaccine Date: _____

Colonoscopy/Cologuard Date: _____ Last Period: _____ ☐ Pregnant ☐ Menopause

☐ Diabetes (Onset Date: _____) ☐ Emphysema ☐ Hernia ☐ Hepatitis ☐ Hypertension

☐ Cancer (List Type): _____) ☐ Parkinson's ☐ Stroke ☐ Heart Attack ☐ Heart Murmur

☐ Other: _____

MY MAIN PROBLEMS/SYMPTOMS: _____

Is condition result of Work or Auto Accident? ☐ No ☐ Yes (please notify receptionist)

MEDICATIONS: ☐ None _____

_____

_____

FAMILY HISTORY: ☐ Bladder Cancer ☐ Prostate Cancer ☐ Kidney Stones ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Other Cancer ☐ Unknown

Family Members: ☐ Mother ☐ Father ☐ Grandmother: (☐ Maternal / ☐ Paternal) ☐ Grandfather:(☐ Maternal / ☐ Paternal)

SOCIAL HISTORY: ☐ Retired Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Tobacco Use: ☐ None ☐ Smoking ☐ Other Tobacco

SURGICAL HISTORY: ☐ None ☐ Hysterectomy ☐ Childbirth: C-Section # _____ Vaginal Delivery # _____

☐ Cystoscopy ☐ Kidney Stone Surgery ☐ Prostate Surgery ☐ Bladder Tack ☐ Bladder Tack

☐ Appendectomy ☐ Back/Hip/Knee ☐ Gallbladder ☐ Heart Bypass ☐ Sling (TVT)

☐ Other:_____

SYSTEMS REVIEW:

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory	☐ Wheezing	☐ Chronic Cough	☐ Shortness of Breath
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic/Lymphatic	☐Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

URINARY SYMPTOM(S):

☐ Frequency ☐ Urgency ☐ Leakage ☐ Straining ☐ Abdominal pain

☐ Bladder pain ☐ Pain in side: R / L ☐ Not emptying bladder ☐ Urinating at night (# _____)