New Patient Form

DATE:
MR #:
NAME:
PRIMARY PHYSICIAN:
REFERRING PHYSICIAN:

HISTORY OF PRESENT ILLNESS

Medication Allergies:

Please list any medication allergies and the reaction you had.

Medications:

Name of Drug	Dose	Times per day	Name of Drug	Dose	Times per day

What is the reason for your visit today?

Location of your problem (ex: kidney, prostate, bladder; please specify right or left side if applicable).

When did the problem begin?

Does anything make the problem worse (ex: walking, lying down, standing, waiting too long to urinate)?

Does anything make the problem better?

How long does the problem last? minutes hours days always

If the problem comes and goes, how often?

Does anything else happen at the same time (ex: headache, nausea, rash)? yes no

How bothersome are your symptoms? 0 = no pain 10 = Severe pain 0 1 2 3 4 5 6 7 8 9 10

For Physician and Nurse Practitioner Use Only (comments/notes):

	Answers/level of service
1 to 3	1 or 2
4+	3 to 5

PAST MEDICAL HISTORY

Have you ever had or do you currently have any of the following conditions?

Condition	Yes	No	Comments
Anemia			
Anxiety			
Arthritis			
Asthma			
Bladder Cancer			
Blood Clots			
Blood Disorder			
Bowel Disease			
Chest Pain			
Colorectal Cancer			
Depression			
Diabetes			
Emphysema/Bronchitis			
Erectile Dysfunction			
Genital Herpes			
GERD			
GU Cancer			
Heart Attack			
HIV			
High Blood Pressure			
Kidney Cancer			
Kidney Stones			
Kidney Disease			
Liver Disease			
Migraines			
Cancer (other)			
MRSAs			
Prostate Cancer			
Prostate Problems			
Rheumatic Fever			
Seizure Disorder			
Sexually Transmitted Disease			
Stroke			
Testicular Cancer			
Testicular Problems			
Thyroid Problems			
Tuberculosis			
Urinary Incontinence			
Varicose Veins			

Women only:

Menstrual history

Age at onset? ____________

First day of last period? ____________

Age of menopause if applicable? ____________

Pregnancies

Total number? ____________

Number of births? ____________ vaginal ____________________________ cesarean ____________

Number of miscarriages? ____________

Number of abortions? ____________

Number of ectopic pregnancies?

Past Surgical History

Surgeries:

Date	Procedure

FAMILY MEDICAL HISTORY

Family history:	If living Age	Health	If deceased Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Mother's parents:				
Father				
Mother				
Father's parents:				
Father				
Mother				

Has any BLOOD relative had any of the following?

	Who?		Who?
Bladder Cancer		Diabetes	
Breast Cancer		Heart Disease	
Kidney Cancer		High Blood Pressure	
Prostate Cancer		Kidney Disease	
Other Cancers		Kidney Stones	
Birth Defects		Stroke	
Bleeding Tendency		Tuberculosis	

PERSONAL HABITS/SOCIAL

Diet/Exercise

Are you on a special diet? yes no

If yes, what type? ____________________

Do you exercise regularly? yes no

If yes, what type and how often per week? 1-2 times 3-4 times 5-6 times Daily

Caffeine

Do you drink caffeine? yes no

How many drinks per day? 0-2 3+

Alcohol

Do you drink alcohol? yes no

If yes, how many drinks per week? ____________________

Have you ever thought, or been told, that you have a drinking problem? yes no

Have you used any of the following? yes no

marijuana cocaine amphetamine pain killers other drugs:

Tobacco

Do you chew tobacco? yes no

Do you smoke now? yes no

How much per day? ____________________

For how long? ____________________

If no, when did you quit?

REVIEW OF SYSTEMS

For Physician and Nurse Practitioner Use Only (comments/notes): Answers/level of service

1 to 3	1 or 2
4+	3 to 5

WEST ALABAMA UROLOGY ASSOCIATES

Please review the list below and check yes or no for each item.

Symptom	Yes	No	Symptom	Yes	No
CONSTITUTIONAL			**GENITOURINARY**		
Fever			Calculi/Stones		
Chills			Blood in urine		
Headaches			Getting up during sleep to go to the bathroom more than 2 times per night		
Fatigue			Pain with urination		
Weight loss			Straining to urinate		
Weight gain			Urethral stricture		
EYES			Frequent urination		
Altered vision			UTI		
Double vision			Urinary retention		
Eye pain			Urinary leakage		
Glasses			Urgent urination		
Cataracts			Erectile/difficulty with ejaculation		
Glaucoma			**MUSCULOSKELETAL**		
ENT/MOUTH			Joint pain		
Ear infections			Neck pain		
Hearing loss			Back pain		
Nose or sinus problems			Muscle pain		
Sore throat or tongue			**INTEGUMENTARY**		
Difficulty swallowing			Rashes or Skin sores		
Teeth problems or dentures			Persistent itch		
ENDOCRINE			**HEMATOLOGIC**		
Unusual hair loss or growth			Easy bruising or bleeding		
Excessive thirst			Swollen glands		
Feeling too hot or cold			Anemia		
Tired/sluggish			**IMMUNOLOGIC/ALLERGIC**		
Thyroid problems			Seasonal allergies		
RESPIRATORY			**NEUROLOGICAL**		
Cough			Dizziness		
Shortness of breath			Tremors		
Wheezing			Numbness/tingling of body parts		
Other			Weakness of arms or legs		
CARDIOVASCULAR			**PSYCHOLOGICAL**		
Chest pain or pressure			Anxiety		
High blood pressure			Feeling down or depressed		
Heart palpitations			Loss of interest in everyday activities		
Swelling of hands or ankles			Sleep disturbances		
GASTROINTESTINAL					
Abdominal pain					
Heartburn/indigestion					
Nausea/vomiting					
Diarrhea					
Constipation					
Recent change in bowel habits					
Blood in stool					

COMMENTS: ______________________________

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Patient/person completing this form: ______________________________ Date: __________

Relationship of person completing this form (if not patient): ______________________________

Physician/PA signature: ______________________________ Date: __________