MRN #: _____

UROLOGY SPECIALISTS CLINIC & SURGICAL CENTER

New Patient Form Date: _____

Patient: _____ DOB: _____ Age: _____

Preferred Pharmacy: _____ Pharmacy Address/City: _____

Mail Order Pharmacy Name: _____ Primary Physician: _____

DRUG ALLERGIES:

Medication	Reaction
1.	
2.	
3.	

OTHER ALLERGIES:

_____ IV Contrast _____ Iodine/Betadine _____ Shellfish _____ Latex _____ Other; Specify _____

CURRENT PRESCRIPTION MEDICATION(S) - *If you have a current list, you may photocopy and attach*

Medication	Dose and Frequency	Who Prescribed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

CURRENT OVER-THE-COUNTER MEDICATION(S), VITAMIN(S), HERBAL SUPPLEMENTS(S):

Name	Dose and Frequency	Who Prescribed
1.		
2.		
3.		

FAMILY HISTORY (alive or deceased, please list any major medical illness):

Mother: _____ Father: _____

Sibling(s): _____ Other(s): _____

Family history of prostate cancer? (Relationship/age/treatment): _____

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PAST MEDICAL HISTORY- *Have you been treated for or diagnosed with any of the following?*

Genitourinary:		**Endocrine:**		**Neurology:**	
	Bladder infection		Diabetes		Multiple sclerosis
	Bladder stone		Extreme thirst		Stroke
	Blood in urine		Extreme tiredness		Parkinson's disease/MSA
	BPH		Hot flashes		Spinal cord injury
	Erectile dysfunction		Hyperthyroidism		Lumbar disk disease
	Interstitial cystitis		Hypothyroidism	**Hematological/Lymphatic:**	
	Kidney stone	**Oncologic:**			Bleeding disorder
	Nocturia (night urination)		Bladder cancer		Low blood count
	Not emptying (retention)		Breast cancer		Enlarged lymph nodes
	Sexually transmitted disease		Kidney cancer		Hepatitis
	Testicular pain		Lung cancer		HIV/AIDS
	Transplant donor or recipient		Prostate cancer	**General:**	
	Trauma- kidney/groin/testicle		Testicular cancer		Anxiety or depression
	Urinary frequency	**Cardiac:**			Chills or fever
	Urinary incontinence/leaking		Coronary artery disease		Glaucoma
	Urinary urgency		Heart attack		High cholesterol
	Urinary tract infection (UTI)		Rhythm disorder		Insomnia
	Vasectomy		High blood pressure		Obesity
	Weak stream		Peripheral vascular disease		Radiation treatment
Pulmonary:		**Gastrointestinal:**			Unexplained weight loss
	Asthma		Abdominal Pain	**Other:**	
	COPD		Heartburn		
	Emphysema		Nausea and/or vomiting		

PAST SURGICAL HISTORY- *Please list prior surgeries.*

1. _____ 2. _____

SOCIAL HISTORY:

Are you sexually active?

Yes: ☐ No: ☐ Contraception Method: _____

Smoking Status:

Current: ☐ Former: ☐ Never: ☐

Packs per day: _____ Number of years: _____ Date quit: _____

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Number of:

Alcoholic beverages per week: _____ Glasses of water per day: _____

Soda/Pop per day: _____ Cups of coffee or caffeinated tea per day: _____

***FEMALE PATIENTS PLEASE CONTINUE WITH FORM. -** *Have you had any of the following?*

	Surgery	Date	Reason
	Partial abdominal hysterectomy (cervix still in place)		
	Total abdominal hysterectomy		
	Vaginal hysterectomy		
	Oophorectomy (removal of ovaries)		
	Vaginal prolapse repair (cystocele, rectocele, enterocele)		
	Uterine prolapse repair		
	Robotic abdominal prolapse repair		
	Burch procedure		
	Sling procedure (mesh used?) Y N		

OB/GYN HISTORY:

- Date of last pap smear: _____
- History of abnormal pap? Yes: ☐ No: ☐
- Any chance you could be pregnant now? Yes: ☐ No: ☐
- Number of pregnancies: _____
    - Complications:

    Gestational Diabetes: ☐ Hypertension: ☐ Preeclampsia: ☐ Other: _____
- Number of deliveries: C-Section: _____ Vaginal: _____
- Any trauma with deliveries (forceps, tearing of vagina or rectum, etc)?: _____
- Age at menopause: _____
- Do you currently use estrogen? Yes: ☐ No: ☐
    - Route?: (Vaginal, oral, patch or cream):_____

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REVIEW OF SYSTEMS: *Please select any current <u>symptoms</u> from the list below.*

Constitutional		**Genitourinary**	
	Fever of chills		Urinary frequency
	Unexplained weight loss or gain		Urinary urgency
HEENT			Waking up at night to urinate
	Sore throat		Urinary leakage with urgency; times per day: ____
	Headaches		Urinary leakage with activity (cough, laugh, sneeze, exercise, etc); times per day: ____
Skin			Sensation of incomplete bladder emptying
	Rash		Difficulty emptying bladder
	New skin lesions; location _____		Difficulty starting stream
Cardiovascular			Weak urinary stream
	Chest pain		UTI; how often: _____
	Leg swelling		Retention of urine
Respiratory			Blood in urine
	Shortness of breath		Burning or pain with urination
	Cough		Kidney stones
Gastrointestinal		**Psychiatric**	
	Nausea and/or vomiting		Anxiety
	Constipation		Depression
	Diarrhea	**Gynecologic**	
	Fecal Incontinence (leakage of stool)		Abnormal vaginal bleeding
	Fecal urgency		Painful menstrual periods
	Straining to defecate		Pain with intercourse
Neurologic			Unusual vaginal discharge
	Muscular weakness		Vaginal dryness
	Poor coordination or tremors		Vaginal pain
	Blurred vision or double vision		Vaginal bulge or heaviness
	Tingling or numbness		Placing fingers in the vagina to help urinate/defecate
Musculoskeletal		**Other**	
	Back Pain or Joint Pain		