UROLOGY SPECIALISTS OF ATLANTA
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English - Spanish

NEW PATIENT INTAKE FORM

PLACE USA PATIENT STICKER HERE

Your Primary Care Doctor:_____ Your Referring Doctor:_____

What would you like to discuss with the doctor today?_____

How long has your issue been going on?_____

Has anything made it better or worse? _____

DO YOU ***CURRENTLY*** HAVE ANY PROBLEMS RELATED TO THE FOLLOWING? (PLEASE CHECK YES/NO FOR ***ALL*** QUESTIONS)

	YES	NO
CONSTITUTIONAL:		
Fever	☐	☐
Unintentional Weight Loss	☐	☐
EYES:		
Unexplained Blurry Vision	☐	☐
CARDIOVASCULAR:		
Chest Pains	☐	☐
GASTROINTESTINAL:		
Constipation	☐	☐
Straining for Bowel Movement	☐	☐
Leakage of Stool	☐	☐
NEUROLOGICAL:		
Tremors	☐	☐
Numbness/Tingling of Legs	☐	☐
Blurry Vision	☐	☐

	YES	NO
GENITOURINARY:		
Weak Stream of Urine	☐	☐
Pushing to Urinate	☐	☐
Frequent Urination Daytime	☐	☐
Frequent Urination Nighttime	☐	☐
Leakage of Urine	☐	☐
Burning with Urination	☐	☐
Blood in the Urine	☐	☐
GENITOURINARY *(For Men Only)*:		
Erection Problems	☐	☐
GENITOURINARY *(For Women Only)*:		
Pain with Intercourse	☐	☐
Vaginal Bulge Sensation	☐	☐

PAST MEDICAL HISTORY: (CHECK ANY MEDICAL CONDITIONS YOU HAVE AND WHEN THEY WERE DIAGNOSED)

☐ ***I HAVE NO MEDICAL PROBLEMS***

☐ Glaucoma _____
☐ Angina _____
☐ Atrial Fibrillation _____
☐ Coronary Heart Disease _____
☐ Heart Attack _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ COPD _____
☐ Crohn's or Ulcerative Colitis _____
☐ Diabetes _____

☐ Diverticulitis _____
☐ Gout _____
☐ Stroke _____
☐ Spine Problems _____
☐ Kidney Insufficiency or Failure _____
☐ Kidney Stones _____
☐ Kidney Cancer _____
☐ Bladder Cancer _____
☐ Any Other Cancer _____
☐ Other _____

For Men Onlv:

☐ Enlarged Prostate (i.e. BPH) _____
☐ Prostatitis _____
☐ Prostate Cancer _____

☐ Testicular Cancer _____
☐ Elevated PSA _____

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For Women Only:

Number of Vaginal Births: _____
Number of Cesarean Sections: _____
☐ Breast Cancer _____
☐ Ovarian Cancer _____
☐ Uterine Cancer _____
☐ Endometriosis _____

PAST SURGICAL HISTORY: (CHECK ANY PAST SURGERIES AND WHEN THEY OCCURRED

☐ ***I HAVE HAD NO SURGERIES***

☐ Amputation _____
☐ Angioplasty or Heart Stent _____
☐ Heart Bypass _____
☐ Heart Pacemaker or Defibrillator _____
☐ Blood Vessel Bypass Surgery _____
☐ AV Fistula (For Dialysis) _____
☐ Peritoneal Catheter (For Dialysis) _____
☐ Hernia Repair _____
☐ Appendix Removal _____
☐ Gallbladder Removal _____
☐ Gastric Bypass Surgery _____
☐ Intestine Surgery _____
☐ Organ Transplant _____
☐ Joint Replacement _____
☐ Back Surgery _____
☐ Kidney Stone Surgery _____
☐ Radiation for Cancer Treatment _____
☐ Other _____

For Men Onlv:

☐ Prostate Surgery _____
☐ Prostate Radiation for Cancer _____
☐ Vasectomy _____
☐ Varicocele Repair _____

For Women Only:

☐ Removal of Ovaries _____
☐ Removal of Uterus (Hysterectomy) _____
☐ Bladder or Urethra Sling, “Tack”, or “Lift” _____

FAMILY MEDICAL HISTORY: (CHECK ANY ILLNESSES IN YOUR IMMEDIATE FAMILY)

☐ ***NO MEDICAL PROBLEMS RUN IN MY FAMILY***

	MOM	DAD	BROTHER	SISTER
☐ Bleeding Disorder	☐	☐	☐	☐
☐ Kidney Stones	☐	☐	☐	☐
☐ Prostate Cancer	N/A	☐	☐	N/A

SOCIAL HISTORY:

Do You Drink Alcohol? ☐ Yes ☐ No If Yes, On average how many drinks per week? _____

Do You Smoke? ☐ Yes ☐ No If Yes, How much and for how long do you smoke? _____

Former Smoker? ☐ Yes ☐ No If Yes, How much did you smoke and when did you quit? _____

ALLERGIES: (PLEASE LIST REACTION NEXT TO ANY ALLERGIES)

☐ ***I HAVE NO KNOWN ALLERGIES***

☐ Penicillin (i.e. Amoxicillin, Augmentin®) _____
☐ Cephalosporins (i.e. Keflex®, Ceftin®) _____
☐ Sulfa (i.e. Bactrim®, Septra®) _____
☐ Macrobid® (i.e. Nitrofurantoin) _____
☐ Fluoroquinolone (i.e. Cipro®, Levaquin®) _____
☐ Tetracycline (i.e. Doxycycline®) _____
☐ Latex _____
☐ Iodine (i.d. CAT Scan Contrast) _____
☐ Morphine _____
☐ Percocet®, Vicodin®, Codeine _____
☐ Other: _____

CURRENT MEDICATIONS: (PLEASE LIST ALL MEDICATIONS, PLEASE ***DO NOT*** WRITE "NO CHANGE" OR "SAME")

☐ ***I DO NOT TAKE ANY MEDICATIONS***

Medication	Dose	Date Started	Reason For Taking Medication

OFFICE USE ONLY:

HEIGHT: _____ INCHES WEIGHT: _____ LBS

BLOOD PRESSURE: _____ / _____ PVR: _____ mL

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