UROLOGY SPECIALISTS OF ATLANTA
5673 PEACHTREE DUNWOODY ROAD • SUITE 910 • ATLANTA, GA 30342
PHONE: (404) 255-3822 • FAX: (404) 255-0495

English - Spanish

RETURN PATIENT INTAKE FORM

PLACE USA PATIENT STICKER HERE

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

	YES	NO
CONSTITUTIONAL:		
Fever	☐	☐
Unintentional Weight Loss	☐	☐
CARDIAC:		
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	☐	☐

SINCE YOUR LAST VISIT TO UROLOGY SPECIALISTS OF ATLANTA HAVE YOU?

1) Been Diagnosed with Any New Medical Condition? ☐ Yes ☐ No

If Yes, Please Provide Details: _____

2) Had Any Surgeries or Procedures? ☐ Yes ☐ No

If Yes, Please Provide Details: _____

3) Been Hospitalized? ☐ Yes ☐ No

If Yes, Please Provide Details: _____

4) Current Medications and Allergies: ***PLEASE CONFIRM ON NEXT PAGE***

5) Your Primary Care Doctor / Your Referring Doctor: ***PLEASE CONFIRM ON NEXT PAGE***

6) Pharmacy: ***PLEASE CONFIRM ON NEXT PAGE***

OFFICE USE ONLY:

HEIGHT: _____ INCHES WEIGHT: _____ LBS

BLOOD PRESSURE: _____ / _____ PVR: _____ mL