New Patient Intake Form | Demographic Information

Patient Name (please print): _____ D.O.B. _____/_____/_____

Patient Phone: H: (____)_____-_____ M: (____)_____-_____ Preferred Contact: ○ H ○ M

Email Address: _____ SSN: ____-___-_____ Sex: ○ F ○ M

Marital Status: ○ M ○ S ○ W ○ D | Children: ○ Y ○ N # _____ | Ethnicity: ○ Asian

○ Black/African American ○ Hispanic/Latino ○ White/Not Hispanic ○ Other Race

○ Am. Indian/Alaskan Native ○ Native Hawaiian/Other Pacific Islander ○ Decline to Specify

Do you have an Advanced Directive/Living Will/Healthcare Surrogate? ○ Yes ○ No

Permanent Address:	Seasonal Address (Include Dates):	Mailing Address:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referring Physician _____ Primary Care Physician _____

Emergency Contact Name: _____ Phone: (____)_____-_____ Relationship: _____

Urology Partners
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New Patient Intake Form
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Allergies

(Please include medication allergies, environmental allergies & food allergies – if you require additional space please continue on page 4)

Allergies	Reaction(s)	Mild, Moderate or Severe

Please check here if a list of additionally allergies have been attached: ☐

Family Medical History

	Mother	Father	Sister	Brother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Age / Deceased								
Prostate Cancer								
Kidney Cancer								
Bladder Cancer								
Colon Cancer								
Other Cancer(s)								
Kidney Failure								
Kidney or Bladder Stones								
Polycystic Kidneys								
Urinary Tract Infections								
Interstitial Cystitis								
Diabetes (Type I or II)								
Cardiovascular Disease								

Social History

Tobacco Use:

Are you a: ○ Current tobacco user, ○ Former tobacco user, ○ Non-tobacco user, ○ Uses tobacco in other forms; specify: _____

If you are a current tobacco user how long have you used tobacco? _____ If you are a former tobacco user when did you quit? _____

How often do you smoke? ○ Daily ○ Sometimes How many cigarettes a day do you smoke? ○ 1ppd ○ ½ppd ○ Less than ½ ppd

Second hand smoke exposure? ○ Yes ○ No If yes, please note: ○ Frequently ○ Sometimes ○ Rarely

Patient Name: _____ D.O.B: ____/____/____

Social History Continued

Alcohol Use:

Do you consume Alcohol? ◯ Y ◯ N What type of alcohol do you drink? ☐ Beer ☐ Wine ☐ Liquor

If yes, how often do you drink? ☐ Daily ☐ Weekly ☐ Socially ☐ Occasionally

Sexual History:

Are you sexually active? ◯ Y ◯ N

Do you currently have or do you have a history of a sexually transmitted infection? ◯ Y ◯ N

If yes, please specify: ☐ HPV ☐ Herpes ☐ HIV/AIDS ☐ Hepatitis (A / B / C) ☐ Gonorrhea ☐ Chlamydia

Other:

Exercise Habits: ◯ Daily ◯ Weekly ◯ Monthly | Dietary Habits: ◯ Specific Diet ◯ Overall Healthy ◯ None

Caffeine Habits: ◯ Daily ◯ Weekly ◯ Monthly ◯ Never

Do you take blood thinners? ◯ Y ◯ N If yes, specify (med./dose/freq.): _____

Review of Systems

(In the last six months, have you experienced any of the following symptoms?)

Constitutional
- ☐ Easy Bruising
- ☐ Change in Appetite
- ☐ Chills/Night Sweats
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss/Gain

Allergies
- ☐ Animal
- ☐ Environmental
- ☐ Food
- ☐ Seasonal

Eyes
- ☐ Double Vision
- ☐ Changes in Vision
- ☐ Blurred Vision
- ☐ Eye Pain
- ☐ Itching/Redness

Ears/Nose/Throat/Mouth
- ☐ Hearing Loss
- ☐ Sinus Infections
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Ringing/Painful Ears

Endocrine
- ☐ Tired/Sluggish
- ☐ Decreased Libido
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Heat Intolerance

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular
- ☐ Swollen Extremities
- ☐ Painful Extremities
- ☐ Chest Pain
- ☐ Palpitations

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion/Heartburn
- ☐ Nausea/Vomiting

Hematologic
- ☐ Blood Clots
- ☐ Bleeding Problems
- ☐ Recent Transfusion
- ☐ Swollen Glands

Genitourinary
- ☐ Weak Stream
- ☐ Awaken to Urinate
- ☐ Leaking of Urine
- ☐ Burning Urination
- ☐ Urgent Urination
- ☐ Not Emptying Bladder
- ☐ Blood in Urine

Musculoskeletal
- ☐ Neck Pain/Stiffness
- ☐ Back Pain/Stiffness
- ☐ Joint Pain/Stiffness
- ☐ Muscle Cramps/Aches
- ☐ Sciatica
- ☐ Swollen Joints

Skin
- ☐ Pigment Changes
- ☐ Changing Moles
- ☐ Open Wound(s)
- ☐ Change in Hair/Nails
- ☐ Rash/Hives/Itching

Neurologic
- ☐ Migraines
- ☐ Fainting/Lightheadedness
- ☐ Memory Loss

Psychiatric
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety

Women Only
- ☐ Prolapse of Bladder
- ☐ Painful Intercourse
- ☐ Vaginal Pain/Discharge

Men Only
- ☐ Difficulty w/ Erections
- ☐ Genital Pain/Swelling
- ☐ Penile Discharge

Patient Name: _____ D.O.B: ____/____/____

Medications

(If you require additional space please continue on page 4)

Medication Name	Dosage	Frequency

Please check here if medication list has been attached: ☐ Please list preferred Pharmacy: _____

Surgical History

(Please provide exact dates for surgical procedures, if known. If not please provide an approximation.)

☐ Skin Cancer Removal	____/____	☐ Colon Resection	____/____	☐ Gall Bladder	____/____
☐ Appendectomy	____/____	☐ PPM/ICD Implant	____/____	☐ Cardiac Stent	____/____
☐ Thyroid	____/____	☐ Lung Surgery	____/____	☐ Hernia (Ing/Abd)	____/____
☐ Hip (Right/Left)	____/____	☐ Knee (Right/Left)	____/____	☐ Back (C/T/L/S)	____/____
☐ Hysterectomy	____/____	☐ Kidney Stone Removal	____/____	☐ Bladder Sling	____/____
☐ Prostatectomy	____/____	☐ Nephrectomy (R/L)	____/____		

☐ Other: _____

Past Medical History

(Please answer the following questions below about your personal <u>past</u> medical history.)

Cardiovascular

☐ Heart Attack ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Valve Problems ☐ Irregular Heartbeat
☐ Heart Murmur ☐ Deep Vein Thrombosis ☐ Anemia ☐ Bleeding Tendency ☐ Congestive Heart Failure

Endocrine

☐ Diabetes ☐ Hyperthyroid ☐ Hypothyroid ☐ Gout

GI

☐ Acid Reflux ☐ Irritable Bowels ☐ Peptic Ulcers ☐ Diverticulitis ☐ Diverticulosis
☐ Crohn's ☐ Colitis ☐ Gallstones ☐ Constipation ☐ Diarrhea

GU

☐ Kidney Stones ☐ Bladder Stones ☐ Recurrent UTIs ☐ BPH ☐ Prostatitis
☐ Hematuria ☐ Erectile Dysfunction ☐ Elevated PSA ☐ Incontinence ☐ Overactive Bladder
☐ Hypogonadism ☐ Interstitial Cystitis ☐ Kidney Disease ☐ Other: _____

EENT

☐ Glaucoma ☐ Cataracts ☐ Vertigo ☐ Chronic Ear Infection

Musculoskeletal

☐ Arthritis ☐ Chronic Back Pain ☐ Chronic Joint Pain ☐ Fibromyalgia

Neurologic

☐ Stroke ☐ Chronic Headaches ☐ Parkinson's ☐ Multiple Sclerosis ☐ Seizures
☐ Polio ☐ Alzheimer's/Dementia ☐ Spinal Cord Injury ☐ Spina bifida

Pulmonary

☐ Emphysema ☐ Asthma ☐ Bronchitis ☐ COPD

Hematology/Oncology

☐ Prostate Cancer ☐ Bladder Cancer ☐ Kidney Cancer ☐ Testicular Cancer ☐ Uterine Cancer
☐ Ovarian Cancer ☐ Colorectal Cancer ☐ Lung Cancer ☐ Leukemia ☐ Lymphoma
☐ Skin Cancer ☐ Other: _____

Patient Name: _____ D.O.B: ____/____/____

Allergies

(Please include medication allergies, environmental allergies & food allergies)

Allergies	Reaction(s)	Mild, Moderate or Severe

Medications

Medication Name	Dosage	Frequency

Tanglewood Professional Center
5809 21st Avenue West
Bradenton, Fl 34209

Riverwalk Professional Park
200 3rd Avenue West, Suite 210
Bradenton, Fl 34205

Lakewood Ranch MOB II
6310 Health Park Way, Suite 100
Lakewood Ranch, Fl 34202

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