

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

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:

Patient/person completing this form: _____ Date: _____

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

Physician/PA signature: _____ Date: _____