Advanced Urologic Associates Intake Form

Today's Date: ____/_____/_____ **Date of Birth: ____/_____/_____**

Name: ______________________ **Primary Care Doctor: ___________________**

Pharmacy: Local Name/Location____________________ Mail Order _____________________

Personal Medical History: Please check any of the following problems you have been treated for at any time.

__ Acid Reflux (GERD)
__ Arthritis
__ Asthma
__ Atrial Fibrillation
__ Blood Clots
__ COPD/Emphysema
__ Diverticulitis
__ Depression
__ Diabetes
__ Glaucoma
__ Heart Disease
__ Heart Attack
__ Heart Valve
__ High Blood Pressure
__ High Cholesterol
__ Kidney Stones
__ Stroke
__ Thyroid Problems
__ Cancer (type)
____
____

Allergies to:

Medications(**name** and **type** of reaction): ___________________
____
Latex: _____ Foods: _____________________Contactants: ________________
Environmental: _______________

Surgical History: (see below for options) **None:** ______

Urological: Please indicate if you have ever had surgery and when:

Bladder: Sling ______ Prolapse ________Tumor _______ Other ____________
Prostate: Removal ______ TURP ______ Biopsy ________ Other ____________
Kidney: Removal ______ Lithotripsy ______ PERC ______ Other ___________
Ureteroscopy __________________

Other Surgical History: Please indicate if you have ever had surgery and when:

Appendectomy _________if yes, done at what age:_____ Back __________
Knee ________________ Number of C-section deliveries ____________
Open Heart ___________________ Heart Valve________________________
Tonsillectomy ________if yes, done at what age:_____
Hernia repair: Open or Laparoscopic (Circle One)
Inguinal, Umbilical or Ventral (Circle One)
Hysterectomy: Partial, Complete (Circle One)
Vaginal or Abdominal (Circle One)
Radiation: Organ _______ Radiation Type ______________ Date __________
Other Surgeries:____

Current Medications: You may bring a copy of medications or medication bottles to appointment if you would like, otherwise list them here.

Medication/Dosage:	Medication/Dosage:
1.____________________________	6. ____________________________
2.____________________________	7. ____________________________
3.____________________________	8. ____________________________
4.____________________________	9. ____________________________
5.____________________________	10. ____________________________

Social History: Circle Y (Yes) or N (No) and answer questions completely

Do you use tobacco products? Y N

- Cigarettes __ Chewing Tobacco__ Cigar __ Pipe # per day ____ # of years______

Have you ever used tobacco products? Y N

- # per day _________ # of years_______ Year Quit __________

Drink alcohol? Y N

- Amount: _____ Daily: Y N Weekly: Y N Occasionally: Y N

Drink caffeine? Y N

- Coffee ____ Tea ____ Soda ____ Energy Drinks___ # Servings per day _____

Do you use illicit drugs? Y N

What is your Occupation? ____

Family History: Check any of the following that pertain to blood related family members.

__ Kidney Stones __ Diabetes __ Thyroid Disease
__ Heart Disease __ Lung Problems __ Stroke
__ Kidney Cancer: relationship: _________________________
__ Bladder Cancer: relationship: _________________________
__Prostate Cancer: relationship: _________________________

Diagnostic Studies:

Urology: Urine Culture ___ Cytology ___ PCA3 ___ Stone Analysis ___ Urodynamics ___

X-rays: KUB ___ IVP ___ Chest x-ray ___ Spine x-ray ___ Bone Density ___ Other ___

CT Scan: Ultrasound ___ Bone scan ___ Renal scan ___ MRI ___ Cardiac/Pulmonary ___

Pregnancy/Birth History: # of Preg ___ # of live Births ___ Vag#___ C-section #___LMP: _____

Review of Systems

Please circle any symptoms you have experienced over the last 30 days.

General
Fever
Chills
Unexplained weight loss
Generalized weakness
Fatigue

Skin
Rash
Itching
Boils

HEENT
Blurred vision
Double vision
Open-angle Glaucoma
Narrow-angle Glaucoma
Sinus Problems

Respiratory
Wheezing
Shortness of breath
Productive cough

Breast
Breast swelling
Breast tenderness

Cardiovascular
Elevated blood pressure
Chest pain
Irregular heart beat
Swelling of extremities
Heart murmur
Varicose veins

Gastrointestinal
Heartburn/Indigestion
Abdominal pain
Nausea +/- Vomiting
Diarrhea
Constipation

GU Male
Urgency
Frequency
Urinating at night
Difficulty emptying bladder
Blood in urine
Loss of urine control
Slow stream
Urinary tract infections
Bladder pain
Kidney stones
Difficulty with erections

Musculoskeletal
Arthritis
Back pain
Joint pain
Neck pain

Neurological
Dizziness
Numbness/tingling
Paralysis

Psychological
Anxiety
Depression
Mood Changes

Endocrine
Excessive thirst
Tired/sluggish
Diabetic problems
Decreased sex drive
Thyroid problems

Hematology
Anemia
Blood clotting problems
Swollen glands

GU Female
Urgency
Frequency
Urinating at night
Difficulty emptying bladder
Blood in urine
Loss of urine control
Slow stream
Urinary tract infections
Bladder pain
Kidney stones
Vaginal discharge
Estrogen supplements

Please list any additional information you would like the physician to know:
____
____
____
____
____
____
____
____
____
____

For Nursing Use:
Ht. _____Wt. ____ BMI ____
WD/WN: Y N A&O x ____
No Acute Distress: Y N
Temp ______
Pulse ______
Resp. ______
BP ________
PVR________
Recent: Lab X-rays
NOTES:
____
____
____