UROLOGY SPECIALISTS OF ATLANTA
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PHONE: (404) 255-3822 • FAX: (404) 255-0495

English - Spanish

Name:_____ Date of Birth: _____/_____/_____ Age: _____

Appointment Date: _____/_____/_____

Your Primary Care Doctor:_____ Your Referring Doctor:_____

PLEASE COMPLETE ALL QUESTIONS / SECTIONS OF THIS FORM

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

How long has your issue been going on?_____

When does it occur? _____

How severe is it? _____

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	☐	☐
Shaking Chills	☐	☐
Unintentional Weight Loss	☐	☐
EYES:		
Unexplained Blurry Vision	☐	☐
CARDIOVASCULAR:		
Chest Pains	☐	☐
Palpitations	☐	☐
RESPIRATORY:		
Wheezing	☐	☐
Shortness of Breath	☐	☐
GASTROINTESTINAL:		
Constipation	☐	☐
Straining for Bowel Movement	☐	☐
Leakage of Stool	☐	☐
ENDOCRINE:		
Hot Flashes	☐	☐
Hot / Cold Intolerance	☐	☐
HEMATOLOGIC:		
Abnormal Bruising	☐	☐
MUSCULOSKELETAL:		
Bone Pain	☐	☐
Back Pain	☐	☐

	YES	NO
NEUROLOGICAL:		
Tremors	☐	☐
Difficulty Walking	☐	☐
Numbness/Tingling of Legs	☐	☐
GENITOURINARY:		
Weak Stream of Urine	☐	☐
Pushing to Urinate	☐	☐
Incomplete Bladder Emptying	☐	☐
Frequent Urination Daytime	☐	☐
Frequent Urination Nighttime	☐	☐
Urgency of Urination	☐	☐
Leakage of Urine	☐	☐
Burning with Urination	☐	☐
Lower Abdominal Pain	☐	☐
Flank Pain	☐	☐
Blood in the Urine	☐	☐
Recurrent Bladder Infections	☐	☐
GENITOURINARY *(For Men Only)*:		
Erection Problems	☐	☐
Ejaculatory Problems	☐	☐
Infertility	☐	☐
GENITOURINARY *(For Women Only)*:		
Pain with Intercourse	☐	☐
Vaginal Bulge Sensation	☐	☐
Pelvic Pain	☐	☐
Last Menstrual Period (Date): _____/_____/_____		

NEW PATIENT INTAKE FORM

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 (i.e. MI) _____
☐ High Cholesterol _____
☐ High Blood Pressure (Hypertension) _____
☐ Asthma _____
☐ COPD _____
☐ Anemia _____
☐ Crohn's or Ulcerative Colitis _____
☐ Irritable Bowel Syndrome _____
☐ Diverticulitis _____
☐ Hepatitis _____

☐ Diabetes _____
☐ Thyroid (Hypo or Hyperthyroid) _____
☐ Gout _____
☐ Fibromyalgia _____
☐ Depression _____
☐ Anxiety _____
☐ 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 _____

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 _____

☐ 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 _____
☐ 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	☐	☐	☐	☐
☐ Heart Disease (Before 55 Years of Age)	☐	☐	☐	☐
☐ Kidney Stones	☐	☐	☐	☐
☐ Prostate Cancer	N/A	☐	☐	N/A
☐ Parkinson's	☐	☐	☐	☐
☐ Multiple Sclerosis	☐	☐	☐	☐

☐ Other _____

SOCIAL HISTORY:

Are You? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Where Do You Live? (i.e. Home, Assisted Living Facility) _____

Occupation: _____

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

NEW PATIENT INTAKE FORM

UROLOGY SPECIALISTS
OF ATLANTA

Northside Hospital MIPS Form

(Northside Hospital and CMS Requires This Form to be Completed Once a Year)

1) Are you currently pregnant? YES / NO

2) Have you had the Pneumomax® (Pneumonia Vaccine)? YES / NO

a. If yes, when did you have it? ____ / _____

3) Have you had a colonoscopy or Fecal Occult Blood Testing? YES / NO

a. If yes, did you have a: COLONOSCOPY / FECAL OCCULT BLOOD

b. Was the result: NORMAL / ABNORMAL

c. When did you have it? ____ / _____

4) How many times in the last year have you had 4 or more alcoholic drinks in a day?

a. 0-1

b. 2 or more times

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