UROLOGY SPECIALISTS OF ATLANTA

5673 PEACHTREE DUNWOODY ROAD • SUITE 910 • ATLANTA, GA 30342
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): ____/____/______

RETURN PATIENT INTAKE FORM

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) Smoking History:

☐ Current Every Day Smoker

☐ Current Some Day Smoker

☐ Former Smoker

☐ Never Smoker