New Patient Intake Form

Urology *of* Indiana

Today's Date:_____/_____/_____

Name: ______________________________ Date of Birth: _____/_____/_____

Age: ____________ Weight: ____________ Height: ____________ Gender: ____________

Primary Dr.: ______________________ Referring Dr.: ______________________

What is the main reason for your visit? ______________________________

Preferred Language: ______________________ Occupation: ______________________

Please circle Race:

African American, Asian, American Indian, Black, Alaskan Native, Hispanic, Native Hawaiian, Caucasian, Other Pacific Islander, Unknown, Other: ______________

Please circle Ethnicity:

Hispanic, Non Hispanic, Latino, Unknown

MEDICATION & ALLERGY LIST

ALLERGIES: None Codeine IVP dye Latex Mycins Penicillin Sulfa drugs

OTHER ALLERGIES: ______________________________

____

PHARMACY NAME & ADDRESS: ______________________________

PHARMACY PHONE & FAX NUMBERS: ______________________________

DATE	PLEASE LIST CURRENT MEDICATIONS	DOSAGE	FREQUENCY	NOTES
	(Include over-the-counter drugs, vitamins, herbals)			

Check any past medical problems:

- ❑ Acid Reflux
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer; Type _____
- ❑ Chronic UTIs
- ❑ Congestive Heart Failure
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Crohn's
- ❑ Dementia
- ❑ Depression
- ❑ Diabetes: # of years ___
- ❑ Diverticulitis
- ❑ Enlarged Prostate
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Attack
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV
- ❑ IBS
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Lupus
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Neurologic Disease
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Parkinsons
- ❑ Peptic Ulcer Disease
- ❑ Peripheral Vascular Disease
- ❑ Rheumatoid Arthritis
- ❑ Seizure Disorder
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Valvular Heart Disease

Other:_____

_____

Check any past surgical history:

	date
❑ Appendectomy	_____
❑ Back Surgery	_____
❑ Heart Bypass	_____
❑ Colon Surgery	_____
❑ Heart Stent	_____
❑ Cystoscopy	_____
❑ Gallbladder Removal	_____
❑ Gastric Bypass	_____
❑ Hernia Repair	_____
❑ Hip Replacement R / L	_____
❑ Kidney Removal R / L	_____
❑ Kidney Stone Removal	_____
❑ Knee Replacement R / L	_____
❑ Laparoscopy	_____
❑ Pacemaker	_____
❑ Tonsilectomy	_____

Gender Specific: Female	date
❑ Bladder Suspension	_____
❑ Breast Biopsy	_____
❑ Cesarean Section, #___	_____
❑ Hysterectomy	_____
❑ Mastectomy R / L	_____
❑ Pubovaginal Sling	_____
❑ Tubal Ligation	_____
❑ Vaginal Delivery, #___	_____
❑ Other:	

_____

_____

_____

_____

_____

Gender Specific: Male	date
❑ Prostate Surgery	_____
❑ Penile Prosthesis	_____
❑ Prostate Biopsy	_____
❑ Scrotal Area Surgery	_____
❑ Testicle Removal	_____
❑ Varicocele Surgery	_____
❑ Vasectomy	_____
❑ Other:	

_____

_____

_____

_____

Check any family history of illness:

Adopted? N Y	Father	Mother	Brother	Sister	Grandparent	Son	Daugher	Runs in Family
❑ Diabetes								
❑ Enlarged Prostate								
❑ High Blood Pressure								
❑ Kidney Stones								
❑ Kidney Failure								
❑ Prostate Cancer								
❑ Stroke								
❑ Urinary Tract Infections								
❑ Cancer, Other								
❑ Other								

Social History

MARITAL STATUS: S M D W Children? N Y # of Sons _____ # of Daughters _____

TOBACCO USE: ❑ Current ❑ Former ❑ Never ❑ Unknown Type:_____ ____ Units per day ____ Years used

Have you tried to quit? N Y Year quit:_____ Passive Smoke Exposure? N Y

Smoker Status: ❑ Current, Every Day ❑ Current status unknown ❑ Former Smoker ❑ Current, Some day smoker

❑ Never smoked ❑ Unknown if ever smoked

CAFFEINE: N Y Type: _____/_____ Amount of caffeine per day _____

ALCOHOL: Drinks alcohol: N Y Formerly Type:_____ Frequency:_____ Amount:_____ Last Drink:____

IMMUNIZATIONS: Tetanus Y N _____ date: Influenza Y N _____ date: Pneumonia Y N _____ date:

Review of Systems:

Check if you are currently experiencing any of the following symptoms. Please mark Yes or No for each selection. Additional information may be added in the Notes section at the bottom of the page.

Constitutional:

No	Yes	
❑	❑	Chills
❑	❑	Fever
❑	❑	Weight Loss
		Other:

Gastrointestinal:

No	Yes	
❑	❑	Abdominal Pain
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Heartburn
❑	❑	Nausea/Vomiting
		Other:

Reproductive - Female:

No	Yes	
❑	❑	Breast Lumps
❑	❑	Breast Pain
❑	❑	Vaginal Discharge
		Other:

Skin:

No	Yes	
❑	❑	Hives
❑	❑	Itching Skin
❑	❑	Rash
		Other:

Eyes/Ears/Nose/Throat:

No	Yes	
❑	❑	Blurred/Double Vision
❑	❑	Hearing Loss
❑	❑	Sinus Infection
❑	❑	Sore Throat
		Other:

Genitourinary:

No	Yes	
❑	❑	Burning with Urination
❑	❑	Blood in Urine
❑	❑	Urinary Frequency
❑	❑	Urinary Incontinence
❑	❑	Inability to Urinate
		Other:

Metabolic/Endocrine:

No	Yes	
❑	❑	Fatigue
❑	❑	Male Breast Enlargement
❑	❑	Hot Flashes
		Other:

Musculoskeletal:

No	Yes	
❑	❑	Back Pain
❑	❑	Joint Pain
❑	❑	Neck Pain
		Other:

Respiratory:

No	Yes	
❑	❑	Chronic Cough
❑	❑	Shortness of Breath
❑	❑	Known TB Exposure
		Other:

Reproductive - Male:

No	Yes	
❑	❑	Penile Discharge
❑	❑	Erectile Dysfunction
		Other:

Neurological:

No	Yes	
❑	❑	Headache
❑	❑	Memory Loss
❑	❑	Seizures
❑	❑	Tremors
		Other:

Hematologic/Lymphatic:

No	Yes	
❑	❑	Easy Bleeding
❑	❑	Swollen Glands
		Other:

Cardiovascular:

No	Yes	
❑	❑	Chest Pain
❑	❑	Heart Murmur
❑	❑	Palpitations
		Other:

Psychiatric:

No	Yes	
❑	❑	Anxiety
❑	❑	Depression
		Other:

NOTES:

_____

_____

American Urological Symptom Score

1. Incomplete emptying:	Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?					
	Not at all ❑ 0 pts	<1 time in 5 ❑ 1 pt	< Half the time ❑ 2 pts	Half the time ❑ 3 pts	> Half the time ❑ 4 pts	Almost always ❑ 5 pts
2. Frequency:	Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?					
	Not at all ❑ 0 pts	<1 time in 5 ❑ 1 pt	< Half the time ❑ 2 pts	Half the time ❑ 3 pts	> Half the time ❑ 4 pts	Almost always ❑ 5 pts
3. Intermittency:	Over the past month, how often have you found that you stopped and started again several times when you urinated?					
	Not at all ❑ 0 pts	<1 time in 5 ❑ 1 pt	< Half the time ❑ 2 pts	Half the time ❑ 3 pts	> Half the time ❑ 4 pts	Almost always ❑ 5 pts
4. Urgency:	Over the past month, how often have you found it difficult to postpone urination?					
	Not at all ❑ 0 pts	<1 time in 5 ❑ 1 pt	< Half the time ❑ 2 pts	Half the time ❑ 3 pts	> Half the time ❑ 4 pts	Almost always ❑ 5 pts
5. Weak-stream:	Over the past month, how often have you had a weak stream?					
	Not at all ❑ 0 pts	<1 time in 5 ❑ 1 pt	< Half the time ❑ 2 pts	Half the time ❑ 3 pts	> Half the time ❑ 4 pts	Almost always ❑ 5 pts
6. Straining:	Over the past month, how often have you had to push or strain to begin urination?					
	Not at all ❑ 0 pts	<1 time in 5 ❑ 1 pt	< Half the time ❑ 2 pts	Half the time ❑ 3 pts	> Half the time ❑ 4 pts	Almost always ❑ 5 pts
7. Nocturia:	Over the past month or so, how many times do you awaken to urinate per night?					
	None ❑ 0 pts	1 time ❑ 1 pt	2 times ❑ 2 pts	3 times ❑ 3 pts	4 times ❑ 4 pts	5 or more times ❑ 5 pts

Total Score _____ (please add all point values above)

Quality of Life Due to Urinary Symptoms:

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

❑ Delighted ❑ Pleased ❑ Mostly satisfied
❑ Mostly dissatisfied ❑ Unhappy ❑ Terrible
❑ Mixed

Patient Signature _____ Date _____

Physician Signature _____ Date _____

Reviewed/updated (initials and dates) _____