

ADVANCED UROLOGY ASSOCIATES, L.L.C.

New Patient Visit

Name: _____ Date of First Visit: _____

Date of Birth: _____ Age: _____ Primary Care Physician: _____

What is the main reason for your visit today?

Chief Complaint: _____

When did you first notice the problem?: _____

Does anything help or make the problem worse?: _____

How long does the problem last?: _____

Does the problem interfere with your daily activities?: _____

Past Medical & Social History

Medical History (please circle all that pertain): Diabetes Hypertension Stroke Chest Pain Cancer Asthma
Heart Disease Ulcer Disease Other: _____

Surgical History: _____

Urologic History (please circle all that pertain): Blood in urine Kidney stones Incontinence of urine Prostatitis

Urinary Tract Infections BPH Other: _____

Do you have a family history of kidney stones? **Yes** **No**

List past urological procedures: _____

List all serious illnesses in your immediate family: _____

Age of Mother: _____ Age of Father: _____ Other Information: _____

Do you smoke?: **Y** **N** If yes, how much: _____

Do you drink alcohol?: **Y** **N** If yes, how much: _____

Are you on a special diet?: **Y** **N** If yes, please explain: _____

Are you allergic to any medications?: **Y** **N** If yes, please list: _____

List all medications that you take, including over the counter and herbal medications: _____

Please continue on other side →

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following system? Circle **YES** or **NO**

Please explain any **YES** answers in space provided

Constitutional Symptoms			Integumentary		
Fever	Y	N	Skin rash	Y	N
Chills	Y	N	Boils	Y	N
Headache	Y	N	Persistent itch	Y	N
Other:			Other:		
Eyes			Musculoskeletal		
Blurred vision	Y	N	Joint pain	Y	N
Double vision	Y	N	Neck pain	Y	N
Pain	Y	N	Back pain	Y	N
Other:			Other:		
Allergic/Immunologic			Ear/Nose/Throat/Mouth		
Hay Fever	Y	N	Ear infection	Y	N
Drug Allergies	Y	N	Sore throat	Y	N
Other:			Sinus problems	Y	N
Neurological			Other:		
Tremors	Y	N	Genitourinary		
Dizzy spells	Y	N	Urine retention	Y	N
Numbness/Tingling	Y	N	Painful urination	Y	N
Other:			Urinary frequency	Y	N
Endocrine			Other:		
Excessive thirst	Y	N	Respiratory		
Too hot/cold	Y	N	Wheezing	Y	N
Tired/sluggish	Y	N	Frequent cough	Y	N
Other:			Shortness of breath	Y	N
Gastrointestinal			Other:		
Abdominal pain	Y	N	Hematologic/Lymphatic		
Nausea/vomiting	Y	N	Swollen glands	Y	N
Indigestion/heartburn	Y	N	Blood clotting problem	Y	N
Other:			Other:		
Cardiovascular			Psychologic		
Chest pain	Y	N	Are you generally satisfied with your life?	Y	N
Varicose veins	Y	N	Do you feel severely depressed?	Y	N
High blood pressure	Y	N	Have you considered suicide?	Y	N
Other:			Other:		

PHYSICIAN USE ONLY

Assessment: _____

Plan: _____
