



PATIENT DEMOGRAPHIC INFORMATION

DATE: _____

NAME _____ SSN: _____
LAST FIRST MI

DOB _____ AGE _____ MALE FEMALE MARITAL STATUS: MARRIED SINGLE

DIVORCED SEPARATED

ADDRESS: _____ WIDOWED PARTNER
STREET CITY, STATE ZIP

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL ADDRESS: _____ PREFERRED CONTACT METHOD:

EMERGENCY CONTACT _____ HOME PHONE CELL PHONE
NAME PHONE NBR RELATION TEXT WORK PHONE
 EMAIL

ETHNICITY _____ PREFERRED LANGUAGE _____

EMPLOYER _____ OCCUPATION _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

INSURANCE INFORMATION (only if card not available):

INSURANCE CARRIER _____ POLICY # _____

GROUP # _____ GROUP NAME _____

POLICY HOLDER INFO (required, unless same as patient): RELATION TO PT _____

NAME _____ DOB _____ SSN _____

GUARANTOR INFO (required for minors): RELATION TO PT _____

NAME _____ DOB _____ SSN _____

CURRENT UROLOGY ISSUE (main reason for today's visit) _____

PREFERRED PHARMACY _____
NAME LOCATION

LAB We perform prostate screening and low testosterone labs in-house. All other labs will be sent to **PPL, LabCorp, BSA, or NWTH**. If your insurance requires you to use a specific lab, please indicate below and notify the clinical staff assisting you and a written order form will be given to you to take to the lab of your choice.

INS REQUIRED LAB _____

PREFERRED OUTSIDE IMAGING CENTER: PREFERRED IMAGING OPEN AIR MRI NWTHS
**ALL IMAGING WILL BE PERFORMED IN-HOUSE WHEN AVAILABLE BSA ADVANCED IMAGING

CARE TEAM:

CARDIOLOGIST _____ NEPHROLOGIST _____

OBGYN _____ ONCOLOGIST _____

PULMONOLOGIST _____ ENDOCRINOLOGIST _____



DRUG ALLERGIES:

DRUG NAME	TYPE OF REACTION

CURRENT MEDICATIONS: (if you have an updated list, please provide to the staff for a copy)

DRUG NAME	DOSAGE	DIRECTIONS

If more room is needed, please use the back.

CURRENT FLU SHOT? YES NO WHEN ADMINISTERED? _____

CURRENT PNEUMONIA SHOT? YES NO WHEN ADMINISTERED? _____

COVID VACCINATION? YES NO WHEN ADMINISTERED? _____

LOCATION OF PROBLEM: ABDOMEN KIDNEY PELVIS BACK GENITALIA OTHER

HOW LONG DOES THE PROBLEM LAST? 15 MINS 30 MINS 1 HOUR OTHER

DESCRIPTION OF PAIN: DULL SHARP DULL THEN SHARP SHARP THEN GONE

ONSET DATE OF PROBLEM? _____

FAMILY HISTORY:

MEDICAL ISSUES:

<p>FATHER: LIVING? YES <input type="checkbox"/> CURRENT AGE _____ NO <input type="checkbox"/> AGE DECEASED _____</p>	<p>CANCER YES <input type="checkbox"/> NO <input type="checkbox"/> ORGAN _____ OTHER _____</p>								
<p>MOTHER: LIVING? YES <input type="checkbox"/> CURRENT AGE _____ NO <input type="checkbox"/> AGE DECEASED _____</p>	<p>CANCER YES <input type="checkbox"/> NO <input type="checkbox"/> ORGAN _____ OTHER _____</p>								
<p># OF BROTHERS: _____ AGES OF THOSE LIVING</p> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td></tr> </table> <p>MEDICAL ISSUES: _____</p>					<p>AGES AT TIME OF DEATH</p> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td><td style="width: 20px; height: 20px;"> </td></tr> </table>				
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SOCIAL HISTORY:

EMPLOYED? NO YES **EMPLOYER** _____

OCCUPATION _____ **MARITAL STATUS** MARRIED SINGLE DIVORCED

EDUCATION LEVEL < 8TH 8 9 10 11 WIDOWED SEPARATED PARTNER
 12 2 YEAR 4 YEAR POST GRADUATE

ALCOHOL INTAKE: NONE OCCASIONAL MODERATE HEAVY

CAFFEINE INTAKE: NONE OCCASIONAL MODERATE HEAVY

ILLICIT DRUGS: YES NO **IV DRUG USE:** YES NO

DOES THE PATIENT HAVE AN ADVANCED DIRECTIVE? YES NO

TOBACCO USE:

NEVER USED ANY TOBACCO PRODUCTS:

CIGARETTES/CIGARS: FORMER SMOKER CURRENT EVERY DAY SMOKER CURRENT SOME DAY SMOKER

HOW MUCH: 1 PPW 2 PPW ¼ PPD ½ PPD 1 ½ PPD 2 PPD 3+ PPD

SMOKELESS TOBACCO: FORMER USER SNUFF USER CHEWS TOBACCO

HOW MUCH: 1 PER DAY 2-4 PER DAY 5+ PER DAY

E-CIGARETTES/VAPE: FORMER USER CURRENT USER

OF YEARS OF TOBACCO USE: _____ **HAS SMOKED SINCE AGE:** _____

PARTICIPATED IN A SMOKING CESSATION PROGRAM? YES NO **WHEN?** _____

SURGICAL PROCEDURES: List all past surgical procedures and the year they were performed

PATIENTS AGE 50 & OVER: HAVE YOU HAD A COLONOSCOPY? YES NO **WHEN:** _____

PROCEDURE	DATE	PROCEDURE	DATE

PAST MEDICAL HISTORY:

CONDITION	YES	NO	CONDITION	YES	NO
BLEEDING DISORDER			HEART DISEASE		
CANCER			HIGH BLOOD PRESSURE		
DIABETES			HIGH CHOLESTROL		
DIVERTICULITIS			KIDNEY STONES		
EMPHYSEMA			MENTAL HEALTH DISORDER		
ENLARGED PROSTATE			SEIZURES		
HIV/HEPATITIS			STROKE		



Please mark any symptoms that you are currently experiencing today.

CONSTITUTIONAL: FEVER NIGHT SWEATS WEIGHT GAIN ____ lbs WEIGHT LOSS ____ lbs
 EXERCISE INTOLERANCE SEDATION LETHARGY CHILLS MALAISE

EYES: WEARS GLASSES/CONTACT LENSES
 DRY EYES IRRITATION VISION CHANGE EYE DISEASE/INJURY

EARS: WEARS HEARING AIDS DIFFICULTY HEARING EAR PAIN

NOSE: FREQUENT NOSEBLEEDS NOSE PROBLEMS SINUS PROBLEMS

MOUTH/THROAT: SORE THROAT BLEEDING GUMS SNORING DRY MOUTH ORAL ABNORMALITIES
 MOUTH ULCER TEETH ABNORMALITIES MOUTH BREATHING RINGING IN EARS SINUSITIS

CARDIOVASCULAR: CHEST PAIN ON EXERTION ARM PAIN ON EXERTION SHORTNESS OF BREATH WHILE WALKING
 SHORTNESS OF BREATH WHEN LYING DOWN PALPITATIONS KNOWN HEART MURMUR
 LIGHT-HEADED ON STANDING ANKLE SWELLING

RESPIRATORY: COUGH WHEEZING SHORTNESS OF BREATH COUGHING UP BLOOD SLEEP APNEA

GASTROINTESTINAL: ABDOMINAL PAIN NAUSEA VOMITTING CONSTIPATION CHANGE IN APPETITE
 BLACK OR TARRY STOOLS FREQUENT DIARRHEA VOMITING BLOOD DYSPEPSIA GERD

GENITOURINARY: URINARY LOSS OF CONTROL DIFFICULTY URINATING INCREASED URINARY FREQUENCY
 HEMTURIA INCOMPLETE EMPTYING

MUSCULOSKELETAL: MUSCLE ACHES MUSCLE WEAKNESS ARTHRALGIAS/JOINT PAIN BACK PAIN
 SWELLING IN THE EXTREMITIES NECK PAIN DIFFICULTY WALKING CRAMPS OSTEOPOROSIS
 FRACTURES



SKIN: ABNORMAL MOLE JAUNDICE RASH ITCHING DRY SKIN GROWTHS/LESIONS LACERATIONS
 NON-HEALING AREAS CHANGES IN HAIR/NAILS PSORIASIS CHANGE IN SKIN COLOR BREAST LUMP

NEUROLOGIC: LOSS OF CONSCIOUSNESS WEAKNESS NUMBNESS SEIZURES DIZZINESS
 FREQUENT OR SEVERE HEADACHES MIGRAINES RESTLESS LEGS TREMOR GAIT DYSFUNCTION
 PARALYSIS

PSYCH: DEPRESSION SLEEP DISTURBANCES FEELING UNSAFE IN RELATIONSHIP RESTLESS SLEEP
 ALCOHOL ABUSE ANXIETY HALLUCINATIONS SUICIDAL THOUGHTS MOOD SWINGS
 MEMORY LOSS AGITATION DEMENTIA DELIRIUM

ENDOCRINE: FATIGUE INCREASED THIRST HAIR LOSS INCREASED HAIR GROWTH COLD INTOLOERANCE

HEMATOLOGIC/LYMPHATIC: SWOLLEN GLANDS EASY BRUISING EXCESSIVE BLEEDING ANEMIA PHLEBITS

ALLERGY/IMMUNOLOGIC: RUNNY NOSE SINUS PRESSURE ITCHING HIVES FREQUENT SNEEZING