Submit Print Form

atlantic urological associates
a professional service corporation

NAME:_____
Date of Birth:_____
Primary Doctor:_____
Who referred you to us?_____
Date:_____

Reason for Visit:

History:

- **Describe Symptoms**_____
- **Describe Previous Treatments**_____
- **Any Recent Lab Tests or X-Rays?**_____
- **Previous Urology Evaluation?**_____
- **Recent ER Visit?**_____

Allergies:

- **List any medicines you are allergic to?**_____
- **Are you allergic to IVP Contrast?** **Y** ○ **N** ○
- **Are you allergic to Shellfish/Iodine?** **Y** ○ **N** ○

Medicine List (Name and Dosage):

- **Prescription Drugs**_____
- **Herbal Medicines & Vitamins**_____
- **Do you carry or take Nitroglycerin for Chest Pains/Angina?** **Y** ○ **N** ○

Past Medical History:

Diabetes	**Y** ○	**N** ○	**Vasectomy**	**Y** ◉	**N** ○
High Blood Pressure	**Y** ◉	**N** ○	**Hysterectomy**	**Y** ○	**N** ○
Glaucoma	**Y** ◉	**N** ○	**Appendix Removal**	**Y** ○	**N** ○
Kidney Disease	**Y** ◉	**N** ○	**Gallbladder Removal**	**Y** ○	**N** ○
Kidney Stones	**Y** ◉	**N** ○	**Hernia Surgery**	**Y** ○	**N** ○
Radiation Therapy	**Y** ○	**N** ○	**Chemotherapy**	**Y** ◉	**N** ○

- **Other Illnesses**_____
  _____
  _____
  _____
- **Other Surgeries**_____
  _____
  _____
  _____
- **Previous Hospitalizations**_____
  _____
  _____
  _____

Social History:

- **Major Occupation (current or previous)**_____
- **Are you Retired** **Y** ○ **N** ○
- **Are you Disabled** **Y** ○ **N** ○
- **Do you Smoke** **Y** ◉ **N** ○ **Quit_____ years ago**
  If yes, how many packs per day_____
  How many years _____
- **Do you drink Alcoholic Beverages** **Y** ◉ **N** ○ **Quit_____years ago**
  If yes, how much_____
- **Do you drink Caffeinated Beverages** **Y** ○ **N** ○
- **If yes, how many per day**_____

Family History:

- **Kidney Stones** **Y** ◉ **N** ○ **Other**_____
- **Prostate Cancer** **Y** ◉ **N** ○ _____
- **Heart Disease** **Y** ◉ **N** ○ _____
- **Diabetes** **Y** ◉ **N** ○ _____

Review of Systems: *Do you have any of the following symptoms?*

Fever/Chills	**Y** ◉	**N** ○	**Chest Pain**	**Y** ○	**N** ○
Nausea/Vomiting	**Y** ◉	**N** ○	**Shortness of Breath**	**Y** ○	**N** ○
Headache	**Y** ◉	**N** ○	**Cough**	**Y** ○	**N** ○
Weight Loss	**Y** ◉	**N** ○	**Wheezing**	**Y** ○	**N** ○
Loss of Appetite	**Y** ◉	**N** ○	**Back/Neck/Joint Pain**	**Y** ○	**N** ○
Dizziness	**Y** ◉	**N** ○	**Blood Clotting Problem**	**Y** ○	**N** ○
Tired/Sluggish	**Y** ◉	**N** ○	**Sinus Problems**	**Y** ○	**N** ○
Abdominal Pain	**Y** ◉	**N** ○	**Blood in Urine**	**Y** ○	**N** ○
Heartburn/Indigestion	**Y** ◉	**N** ○	**Burning with Urination**	**Y** ○	**N** ○
Blurry Vision	**Y** ◉	**N** ○	**Urinary Leakage**	**Y** ○	**N** ○

Physician Signature-_____ **Date-**__/__/__