ADMINISTRATIVE OFFICES
12109 COUNTY RD. 103
OXFORD, FL 34484
352-391-6000

Florida Care Centers

Blountstown

Carrabelle

Daytona Beach

DeLand

Homosassa

Inverness

Leesburg

Marianna

New Smyrna Beach

Ocala

Orange City

Oxford

Palm Coast

Panama City

Perry

Port Orange

St. Augustine

Tallahassee

Let us take this opportunity to welcome you as a new patient to our practice.

We are enclosing patient history and information forms for you to complete. Some of these questions may seem unrelated to your problem. However, your cooperation in completeing the history form will help us in diagnosing and treating your illness, as well as understanding the relation to other problems you may have had. Please answer ALL questions and bring these completed forms with you when you come in for your appointment.

It is important to bring your insurance card on the day of your appointment.

We accept Medicare assignment; however, you are responsible for any deductible and the 20% difference between Medicare allowable and the Medicare payment. Payment of your portion is expected at the time services are rendered. If your insurance plan requires a co-pay, please be prepared to pay it at the time services are rendered.

If you are unable to keep your scheduled appointment, for any reason, please call us immediately so we may give this time to someone else.

PLEASE BRING A LIST OF YOUR CURRENT MEDICATIONS WITH YOU.

Thank you,

The Physicians and Staff
Advanced Urology Institute

Advanced Urology, Daytona
545 Health Blvd
Daytona Beach, FL 32114

Advanced Urology, Port Orange
900 N. Swallow Tail Dr. #106
Port Orange, FL 32127

ADVANCED UROLOGY INSTITUTE
DAYTONA DIVISION

PATIENT NAME: ______________________ **DATE OF BIRTH:** ______________

TODAY'S DATE: ____________ **REFERRED BY:** ________________

MAIN SYMPTOM (main reason you came to see the urologist and how long you have had the problem: ____

________________________________ **PHARMACY:** ________________

SEVERITY QUALITY LOCATION DURATION TIMING CONTEXT
ASSOC. SYMPTOMS MODIFYING FACTORS

Do you suffer from any of the following:
(Please circle one response)

Urinate very frequently	YES	NO
Strong urge to urinate	YES	NO
Unable to control the urge and leaked	YES	NO
Leak with coughing, sneezing, or strenuous activity	YES	NO
Have to wait too long to start	YES	NO
Takes a long time to empty bladder	YES	NO
Poor flow of urine	YES	NO
Slow stream of urine	YES	NO
Dribbling after urination	YES	NO
Interrupted, stop and go stream	YES	NO
Do you strain to urinate	YES	NO
Feeling of incomplete emptying and need to go again	YES	NO

How many times do you urinate: Day: ______
Night: ______

Do you pass blood in the urine	YES	NO
Pain while passing blood in the urine	YES	NO
History of pelvic infection	YES	NO
Problem with sexual function	YES	NO
Have you had recurrent urinary tract infections	YES	NO

PAST UROLOGICAL HISTORY:

Have you had VD, Gonorrhea, Chlamydia, or Herpes	YES	NO
Kidney stones/urinary stones	YES	NO

If so, when:

Any surgery for urinary stones	YES	NO
Cancer of urinary bladder or kidney	YES	NO
Ever had kidney x-rays (IVP)	YES	NO

When: _______ Where: ____________________

Any history of cancer	YES	NO

If so, what type of cancer: ____________________
If so, when were you diagnosed: ____________________

ARE YOU ALLERGIC TO IODINE, SEAFOOD, OR X-RAY DYE? **YES** **NO**

PAST MEDICAL HISTORY
any history of:
heart disease angina stroke
diabetes high blood pressure
high cholesterol acid reflux COPD

PAST ILLNESS/INJURIES with dates:

____
____
____

PAST SURGERIES with dates:

____
____
____

ARE YOU CURRENTLY ON:
blood thinners (Coumadin, Plavix (Clopidogrel) Eliquis, Pradaxa, Xarelto, Brilinta, Aggrenox, etc)
Aspirin Vitamin E steroids
insulin

ALLERGIES: List all medications that you are allergic to:

____
____

MEDICATIONS that you are taking daily with strength and how often

____
____
____
____
____
____
____

SOCIAL HISTORY:

Major Occupation (current or previous)____________________________

Are you retired	YES	NO
Are you disabled	YES	NO
Do you smoke	YES	NO

If yes, how many packs per day______________How many years____________

If quit, how many years ago?______________

Do you drink alcoholic beverages YES NO

If yes, how much_______________

If quit how many years ago ____________

Do you drink caffeinated beverages YES NO

If yes, how many per day_____________

Do you use recreational drugs YES NO

Have you ever had a blood transfusion YES NO

FAMILY HISTORY:

Kidney stones	YES	NO
Prostate cancer	YES	NO
Heart disease	YES	NO
Diabetes	YES	NO

Other:________________

REVIEW OF SYMPTOMS: Do you have any of the following symptoms? Please circle any symptoms that you have

Fever	Chills	Cataracts
Blurry vision	Glaucoma	Sore throat
Hearing loss	Sinus problem/congestion	Swollen ankles
Chest Pains	Irregular heartbeats	Cough
Shortness of breath	Wheezing	O2 use
Abdominal pain	Nausea/vomiting	Diarrhea
Hematuria (blood in urine)	Decreased libido	Constipation
Erectile dysfunction	Joint pain	Urinary leakage
Chronic back pain	History of skin cancer	Walk with cane or walker
Rashes	Tingling	Current skin lesions
Numbness	Panic attacks	Dizziness
Depression	Weight loss	Headaches
		Poor memory

Did you receive the flu shot this year? YES NO

Have you had the pneumonia vaccine within the last 10 years?	YES	NO	Approximate date: ___________
Have you had a colonoscopy within the last 10 years?	YES	NO	Approximate date: ___________