Patient Name _____ Date _____

MRN

PHYSICIAN NOTES

Are you currently experiencing any of the following...(Please check all that apply)

- ☐ Frequent Headache
- ☐ Fever/Chills
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Hepatitis
- ☐ Depression
- ☐ Anxiety
- ☐ Overly Stressed
- ☐ Psychological Problems
- ☐ Cataract
- ☐ Glaucoma
- ☐ Blurred/Double Vision
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Uncontrolled Loss of Urine
- ☐ Swollen Glands
- ☐ Easy Bleeding or Bruising
- ☐ Swollen Lymph Nodes
- ☐ Ear Infection
- ☐ Bleeding Gums
- ☐ Sore Throat
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Seasonal Allergies
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Skin Rash
- ☐ Skin Lesions
- ☐ Excessive Thirst
- ☐ Feeling of Being Tired
- ☐ Diagnosed with HIV
- ☐ Shortness of Breath
- ☐ Trouble Breathing
- ☐ Dizzy Spells
- ☐ Numbness/Tingling
- ☐ I have not experienced any of the above.

What is your Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widow

What is your occupation? _____ Number of Children? _____

Do you smoke? ☐ Yes ☐ No

If yes, # of packs per day? ☐ Less than one ☐ One ☐ Two ☐ Three or more

Do you have a history of drug abuse? ☐ Yes ☐ No

Do you have a high intake of caffeine? ☐ Yes ☐ No

If yes, please specifiy (coke, tea, coffee, etc) _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, How much? ☐ Social ☐ Light ☐ Moderate ☐ Excessive

FEMALE PATIENTS ONLY

Do you have menstrual periods? ☐ Yes ☐ No

If yes, are they regular? ☐ Yes ☐ No

When was your last menstrual period? ____/____/____

Is there a chance you may be pregnant? ☐ Yes ☐ No

Patient's Signature _____ **Date** _____

Impression	Plan

Physician's Signature _____ **Date** _____

Gainesville Urology - New Patient History Form

MRN:

☐ New Patient ☐ New Problem ☐ Update This is a confidential document. Please fill out completely

PHYSICIAN NOTES

NAME _____
Last First MI

DATE ____/____/____ DOB ____/____/____ AGE _____ SEX M F

Who is your Primary Care Physician? _____

Who referred you to our practice? _____

In detail, please describe the main reason for your visit today. _____

_____

Where is the problem located? ☐ Front ☐ Side
☐ Back ☐ Genitalia
☐ Other _____

What side is the problem located on? ☐ Left ☐ Right

How long has the problem existed? ☐ 1-2 Days ☐ One Month
☐ 2 Weeks ☐ Over One Year
☐ Other _____

Does anything help ease or make this problem worse?
☐ Sitting/Standing ☐ Lying Down
☐ Pressure ☐ Hot/Cold Packs
☐ Other _____

Are there other symptoms associated with this problem?
☐ Fever/Chills ☐ Nausea/Vomiting
☐ Headache ☐ Difficult Urination
☐ Other _____

Does this problem affect your daily life style? ☐ Yes ☐ No

If yes, please describe _____

Circle the number that best describes your problem.
Severe 10 9 8 7 6 5 4 3 2 1 Tolerable

Do you have any drug allergies? ☐ Yes ☐ No If yes, please list _____

_____

Do you take any medication? ☐ Yes ☐ No If yes, please list _____

_____

Have you ever undergone a surgical procedure?
☐ Yes ☐ No

If yes, please list _____

_____

Myself / Family has a history of.....(Please Check all that Apply)

	Myself	Family	RELATIONSHIP OF FAMILY MEMBER
Cancer (type) _____	☐	☐	
Heart Disease	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Stroke	☐	☐	
Stomach Ulcers	☐	☐	
Seizures	☐	☐	
High Cholesterol	☐	☐	
Dementia	☐	☐	
Arthritis	☐	☐	
Chronic Back Pain	☐	☐	
Sleep Apnea	☐	☐	
Other	☐	☐	