Broward Urology Center
New Patient Intake Form

We'd like to welcome you as a new patient! Please take the time to fill out this form as accurately as possible so we can give you the best service. If you are a returning patient, it's likely been 3 years since we last saw you, thus please give us the updated information in the form below. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

Personal Information

First Name: _____ Last Name: _____ Age: ____ DOB: ____/_____/_____

Sex/Gender: _____ Marital Status: _____ Occupation:(current or former)_____

Race: □Black/African American □White □American Indian □Hispanic/Latino □Asian □Unknown/Declined
Ethnicity: □Black/African American □White □American Indian □Hispanic/Latino □Asian □Unknown/Declined
Primary Language: □English □Español □Français □Kreyòl □ Русский □Italiano Other: _____

Contact Information

Address: _____
_____
Email: _____
Mobile Phone: _____
Home Phone: _____
Work Phone: _____

Emergency Contact: _____
Relationship: _____
Emergency Contact Phone: _____
Do you have a living will? □Yes □ No
Who would make medical decisions for you if you were unable to do so yourself?_____

Referring Doctor: _____
Referring Doctor Phone: _____
Referring Doctor Fax: _____

Primary Doctor (PCP): _____
PCP Phone: _____
PCP Fax: _____

Pharmacy: _____ **Pharmacy Phone**: _____
Do you give our office permission to contact your pharmacy for a list of your medications? □Yes □ No

Please list ALL your current doctors besides your PCP (i.e. pulmonologist, oncologist, internist, cardiologist, etc…)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Medical Illnesses that Run in the Family (write relationship)

- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ Urinary Tract Infections
- ☐ Cancer, type: _____
- ☐ Other

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Reason I am here:

- ☐ Urinary Infection
- ☐ Urinary Leakage
- ☐ Difficulty with Urination
- ☐ Frequency of Urination
- ☐ Blood in the Urine
- ☐ Bladder Cancer
- ☐ Overactive Bladder
- ☐ Kidney Stones
- ☐ Kidney Tumor
- ☐ Kidney Cyst
- ☐ High PSA
- ☐ Prostate Infection
- ☐ Prostate Cancer
- ☐ Sexual Problems
- ☐ Testicle Problems
- ☐ Low Testosterone
- ☐ Fertility Problems
- ☐ Other:_____

Explain:_____

_____

My other medical problems <u>are or have been</u>:

- ☐ Heartburn
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots in Leg or Lungs
- ☐ Chronic back pain
- ☐ Cancer; Type _____
- ☐ Chronic Urinary Infections
- ☐ COPD / Emphysema
- ☐ Crohn's
- ☐ Dementia
- ☐ Depression
- ☐ Drug / Alcohol Abuse
- ☐ Sugar Diabetes: # of years ___
- ☐ Other:_____
- ☐ Diverticulitis
- ☐ Enlarged Prostate
- ☐ Glaucoma
- ☐ Gonorrhea / Chlamydia
- ☐ Gout
- ☐ Gynecological problems
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Low Testosterone
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Overweight / Obesity
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease

My Previous Surgeries or Procedures:

Procedure	Date		Date		Date
☐ Appendix surgery		☐ Knee Replacement R / L		☐ Scrotal Surgery	
☐ Back Surgery		☐ Pacemaker		☐ Testicle Removal	
☐ Heart Bypass		☐ C-section, #___		☐ Varicocele Surgery	
☐ Colon Surgery		☐ Hysterectomy		☐ Vasectomy	
☐ Heart Stent		☐ Bladder Sling		☐ Bladder Tumor Surgery	
☐ Cystoscopy		☐ Vaginal Delivery, #___		☐ **Pneumonia Vaccine**	
☐ Gallbladder Removal		☐ Prolapse Surgery		☐ **Colonoscopy**	
☐ Gastric Bypass		☐ Radiation Treatment		☐ Dental Surgery	
☐ Hernia Repair R/L		☐ Prostate Surgery		☐	
☐ Hip Replacement R/L		☐ Prostate Removal		☐	
☐ Kidney Removal R / L		☐ Prostate Biopsy		☐	

My life-style:

Exercise: ☐ No ☐ Yes
Special Diet: ☐ No ☐ Yes: _____
Smoking Tobacco: ☐ Never ☐ Current ☐ Former #_____ packs per day #____ years
Need help quitting? ☐ No ☐ Yes
Alcohol Use: ☐ No ☐ Yes : amount _____ frequency _____
Caffeine drinks per day: _____

Previous or Current Drug use: ☐ No ☐ Yes
What types of drugs? _____
Ok with Blood Transfusions?: ☐ No ☐ Yes
Do you have: Living Will? ☐No ☐Yes
Sexually Active?: ☐ No ☐ Yes
Sexual partner preference:_____
Hobbies: _____

MEDICATION & FOOD ALLERGIES:
☐None ☐Codeine ☐IV dye ☐Latex ☐Penicillin ☐Sulfa Drugs ☐Other:_____

Current Medications, Vitamins & Supplements

	Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency
1				8				15			
2				9				16			
3				10				17			
4				11				18			
5				12				19			
6				13				20			
7				14				21			

Are you on **Blood Thinners** Like:
☐Aspirin ☐Plavix ☐Coumadin/Warfarin ☐Advil ☐Fish Oil ☐Vitamin E ☐Xarelto ☐Pradaxa ☐Eliquis

Review of Systems

CIRCLE the symptoms you are **currently experiencing**.

Constitutional

Fever	Weight Gain (___ lbs)	Sleep Disturbances
Chills	Weight Loss (___ lbs)	Other:

Head, Eyes, Ears, Nose, and Throat

Vision Problem	Congestion	Nosebleed
Decreased Hearing	Snoring	Ringing in Ears
Double Vision	Dry Mouth	Vertigo
Glaucoma	Sore Throat	Earache
Cataracts	Hoarseness	Other:

Cardiovascular

Chest Pain	Cold Hands or Feet	Using Multiple Pillows to Sleep
Palpitations (Heart Racing)	Leg Pain w/ Walking	Other:
Ankle / Leg Swelling	Irregular Heart Beats	

Respiratory

Shortness of Breath	Wheezing	Other:
Cough	Coughing Up Blood	
Rapid Breathing	Coughing Up Sputum	

Gastrointestinal

Abdominal Pain	Black/Tarry Stools	Bowel Incontinence
Blood in Stool	Decreased Appetite	Rectal Pain
Nausea	Yellow Skin	Constipation
Vomiting	Trouble Swallowing	Other:
Diarrhea	Heartburn	

Neurological

Headache	Numbness/ Tingling	Memory Lapses/Loss
Dizziness	Seizures	Other:
Weakness in Legs / Arms	Fainting (Syncope)	
Confusion	Tremor	

Musculoskeletal

Joint Pain	Limb Pain	Muscle Pain
Neck Pain	Joint Swelling	Muscle Weakness
Back Pain	Muscle Cramps	Leg SwellingOther:

Urinary

Frequent Urination	Painful Urination	Urinary Infections
Urinary Leakage / Accidents	Night Time Urination	Other:
Urinary Urgency (can't hold)	Blood in the Urine	

Male Health

Penile Pain	Penile Discharge	Recent STD
Erection Problems	Change in Libido (sex drive)	Foreskin Problems
Premature Ejaculation	Scrotal/Testicular Pain	Other:
Penile/Scrotal Rash	Fertility Problems	

Female Health

Change in Libido (sex drive)	Heavy Period Bleeding Orgasm	Recent STD
Painful Intercourse	Problems	Other:
Vaginal Discharge	Vaginal Dryness	
Vaginal Bleeding	Heavy Period Bleeding	
Irreg. Monthly Cycles	Fertility Problems	

Skin

Rash	Unusual Growth	Other:
Dry Skin	Itching	
Skin Wound	Skin Cancer	

Psychiatric

Depression	Anxiety
Hallucinations	Other:

Hematologic/Lymphatic

Easy Bruising	Swollen Lymph Nodes
Easy Bleeding	Other:

Endocrine

Excessive Thirst	Heat Intolerance	Other:
Cold Intolerance	Changes- Hair/Skin	