DATE: _____

***Patient Intake Form***

***Urological Associates of Bridgeport, PC***

# Please complete and bring with you to your appointment.

*Name*: _____ SSN#_____ *Date of Birth*:____/____/_____

***Contact Information***: (Please ***circle*** best daytime number for us to reach you on)

Home_____ Cell_____ Work _____

Address: _____
City/State/Zip_____ Email:_____

Primary Care Provider: _____ Referring Provider_____

**Marital Status**: ___ Married ___Single ___Divorced ___Widowed ___Annulled

___Legally Separated ___Life Partner ___Unknown/Declined

**Race**: ___White ___ Black/African American ___ American Indian or Alaska Native

___Eskimo ___ Hispanic/Latino ___ Asian ____Native Hawaiian or Pacific Islander ____ Unknown/Declined

**Primary Language**: ___ English ___ Spanish ___ French ___ German ___ Portuguese ___ Russian

___ Chinese ___ Japanese ___ Italian ___ Vietnamese ___ Arabic ___ Unknown/Declined

**Ethnicity**: __ Non Hispanic or Latino ___Hispanic or Latino ____Unknown/Declined

## If patient is a minor, please complete the information below:

Parent/Guardian Name:_____

Parent/Guardian DOB:_____ Patient/Guardian SSN#_____

Patient/Guardian Address:_____

_____
City State Zipcode

Name of insured:_____

Relationship to Patient:_____ DOB:_____ SSN#_____

DATE: _____

***Patient Intake Form***

***Urological Associates of Bridgeport, PC***

# Please complete and bring with you to your appointment.

*Name*: _____ SSN#_____ *Date of Birth*:____/____/_____

**Pharmacy Information**:

Pharmacy Name and location: _____Phone: _____

Primary Care Provider: _____ Referring Provider_____

***Medical Information:***

Reason for visit today:_____

Allergies / reaction_____

***Medications List***

**(please include over the counter/vitamins)**

| Name | Dose | How often taken/frequency? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
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| | | |
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| | | |
| | | |
| | | |
| | | |

***Surgeries***

**(please list all the surgeries you have had and the approximate date)**

| Surgery | Approximate date |
|---|---|
| | |
| | |
| | |
| | |
| | |

*Name*: _____ SSN#_____ *Date of Birth*:____/____/_____

***Medical Conditions*** ***(Please list)***

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

***Family History*** ***(please check all that apply)***

| | **Family History** | **Family Relationship** |
|---|---|---|
| | Prostate Cancer | |
| | Kidney stones | |
| | Heart disease | |
| | Diabetes | |
| | Stroke | |
| | High Blood Pressure | |
| | Cancer (please specify) | |
| | Other (please specify) | |
| | | |

## *Personal Information*

**Recreational Drug use**: ____No ___Yes _____ Type(s)

**Caffeine use**: _____ per _____ day/week/month

**Have you ever had a Blood Transfusion?** _____Yes _____ No

**Smoking History:**

____ Current daily smoker ____ Currently some day smoker ____ Former Smoker
____ Never Smoked ____ Current smoking status unknown ____ Unknown if ever smoked

How much do you smoke? _____ packs per day When did you quit smoking? _____
How long did you smoke? _____ Smokeless tobacco use? _____

**Alcohol Use**:

*Alcohol Use*: ____ Yes _____ Not anymore _____ Never Drank

*Number drinks*: _____# drinks per _____ day/week/month
*Type of drink*: ____ Beer____Liquor ____Wine
*Drinking Habits*: ____ Social ____Light ____ Moderate ____Excessive

**Occupation** (current or former) _____

*Name*: _____ SSN#_____ *Date of Birth*:____/____/_____

## ***Review of Systems***

Please **circle** all that apply

**Constitutional Symptoms**

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |
| Other _____ | | |

**Eyes**

| | | |
|---|---|---|
| Blurred vision | Y | N |
| Double vision | Y | N |
| Pain | Y | N |
| Other_____ | | |

**Allergy/Immune**

| | | |
|---|---|---|
| Hay fever | Y | N |
| Drug allergies | Y | N |
| Other | | |

**Neurological**

| | | |
|---|---|---|
| Tremors | Y | N |
| Dizzy spells | Y | N |
| Numbness/tingling | Y | N |
| Other_____ | | |

**Integumentary**

| | | |
|---|---|---|
| Skin Rash | Y | N |
| Boils | Y | N |
| Persistent Itch | Y | N |

**Endocrine**

| | | |
|---|---|---|
| Excessive thirst | Y | N |
| Too hot/cold | Y | N |
| Tired/sluggish | Y | N |
| Other_____ | | |

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | Y | N |
| Nausea /vomiting | Y | N |
| Indigestion/heartburn | Y | N |
| Other_____ | | |

**Genitourinary (Males)**

| | | |
|---|---|---|
| Erection difficulty | Y | N |
| Low sex drive | Y | N |
| Premature Ejaculation | Y | N |
| Other_____ | | |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint pain | Y | N |
| Neck pain | Y | N |
| Back pain | Y | N |
| Other_____ | | |

**Ear/Nose/Throat**

| | | |
|---|---|---|
| Ear infection | Y | N |
| Sore throat | Y | N |
| Sinus problems | Y | N |
| Other_____ | | |

**Respiratory**

| | | |
|---|---|---|
| Wheezing | Y | N |
| Frequent Cough | Y | N |
| Shortness of breath | Y | N |
| Other_____ | | |

**Cardiovascular**

| | | |
|---|---|---|
| Chest Pain | Y | N |
| Varicose veins | Y | N |
| High Blood Pressure | Y | N |
| Other _____ | | |

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Swollen glands | Y | N |
| Blood clotting problem | Y | N |
| Other_____ | | |