DATE: ________________

Patient Demographic 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__________________________

Primary Language: (please circle) English Spanish French German Portuguese Russian

Chinese Japanese Italian Vietnamese Arabic Unknown/Declined

Race: (please circle) White Black/African American American Indian Asian Unknown/Declined

Marital Status: (please circle) Married Single Divorced Widowed Annulled Legally Separated

Life Partner Unknown/Declined

Ethnicity: (please circle) 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 Zip code

Name of insured:____

Relationship to Patient:______________________________ DOB:________ SSN#_____________________

DATE: _______________

Patient Clinical 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____

Height: _______ Weight:________ Date of last colonoscopy (approx.)_____________

Have you received a pneumonia vaccine?_______ when __________

Medications List

(please include over the counter/vitamins)

Name	Dose	How often taken/frequency?

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_______________		