MANCHESTER UROLOGY ASSOCIATES, PA

NEW PATIENT HISTORY FORM

Last Name _____ First Name _____ Middle _____
Today's Date ____/____/____ Age _____ Date of Birth ____/_____/_____
Phone: Home:_____ Work: _____ Cell: _____
Please indicate preferred number
Mailing Address: _____
Referring Physicians Name _____ Location _____
Does your insurance prefer that you use a specific laboratory? Preferred Lab: _____
Pharmacy Name:_____ Location:_____

Answer on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess.

Main Reason for your visit today:

_____

How much do you weigh? _____ How tall are you? _____

Allergies & Reactions to medications:

Medication:	Reaction:	Medication:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list the medications and/or over-the-counter, herbal supplements, vitamins, or homeopathic intake. Please include: Anti coagulants (blood thinners), including Aspirin, Coumadin (Warfarin), Plavix (Clopidogrel), etc.

_____
_____
_____
_____

Personal Medical History:

Heart Disease Yes / No **Myocardial Infarction (heart attack)** Yes / No **Angina (chest pain)** Yes / No
Do you have cardiac stents? Yes / No What type? _____
If "yes" When was it placed and by whom? _____
Do you have a pacemaker, mechanical, or replacement valve, or implant? _____
If "yes" when was it placed and by whom? _____
Who is your cardiologist? _____
Cancer (type) _____ _ Yes / No **High Blood Pressure** Yes / No **High Cholesterol** Yes / No
Who is your oncologist? _____
Diabetes Type I Yes / No **Diabetes Type II** Yes / No **Thyroid Problems** Yes / No
Gout Yes / No **Asthma** Yes / No **Lung disease** Yes / No

COPD Yes / No **Kidney Disease** Yes / No **Kidney Stones** Yes / No
Hepatitis A Yes / No **Hepatitis** B Yes / No **Hepatitis** C Yes / No
Stroke Yes / No **Cerebral Vascular Accident** Yes / No **Transient Ischemic Attack** Yes / No
Multiple Sclerosis Yes / No **Parkinson's Disease** Yes / No **Alzheimer Disease** Yes / No
GERD Yes / No D**epression** Yes / No **Anxiety** Yes / No
(gastroesophageal reflux disease)
Bipolar Disorder Yes / No **Cataracts** Yes / No **Glaucoma** Yes / No

Surgical History:

Abdominal Surgery	Yes / No	**Bladder Sling**	Yes / No
Type of Abdominal Surgery: _____			
Bladder Surgery	Yes / No	**Cardiac Bypass Surgery**	Yes / No
Cardiac Valve Surgery	Yes / No	**Defibrillator**	Yes / No
Hysterectomy	Yes / No	**Kidney Stone Surgery**	Yes / No
Kidney Surgery	Yes / No	**Pacemaker**	Yes / No
Prostate Surgery	Yes / No	**Shoulder Surgery**	Yes / No
Spinal Surgery	Yes / No	**Total Hip**	Yes / No
Total Knee	Yes / No	**Cardiac Stents**	Yes / No
Vascular Surgery	Yes / No	**Vasectomy**	Yes / No

Other _____

Has it been recommended that you take antibiotics prior to dental or other procedures? Yes / No

Family History (please indicate yes or no): if your parents, grandparents or any siblings have has the following conditions:

Yes / No **Alzheimers/Dementia**
Yes / No **Asthma/ COPD**
(Chronic Obstructive Pulmonary Disease)
Yes / No **Diabetes**
Yes / No **Heart Disease**
Yes / No **Heart Attack**
Yes / No **Cancer (type) _____**
Yes / No **Kidney Disease**
Yes / No **Kidney Stones**
Yes / No **High Cholesterol**
Yes / No **Gout**
Yes / No **Stroke**
Yes / No **High Blood Pressure**

Social History (please check those that apply):

Cigarettes: Never: _____ Quit: _____ (when) _____
Current Smoker: _____ packs/day _____ # of years _____

Alcohol Use:
Do you drink alcohol: Yes _____ No _____ Drinks per week: _____

Do you drink caffeinated beverages? Please list how much every day:
Coffee _____ Tea _____
Soda _____ Other _____

Mobility:
Yes / No Are you able to walk independently?
Yes / No Do you use an assistive device? _____ Cane _____ Walker _____ Wheelchair _____ Scooter
If yes, can you stand and pivot? _____

REVIEW OF SYMPTOMS: Please check any **current** symptoms you are experiencing

General
____ Recent fevers/sweats ____ Chills _____ Headache
____ Change of appetite ____ Unexplained fatigue _____ Sleeping Difficulty
____ Unexplained weight loss/gain

Skin
_____ Rash ____ Non healing lesions

Eyes/Ears/Nose/Throat/Mouth
____ Glaucoma ____ Ear pain ____ Persistent sore throat
____ Blurring or double vision ____ Hay fever ____ Difficulty hearing
____ Cataracts ____ Allergies ____ Ringing in ears
____ Glasses/Contacts ____ Congestion ____ Trouble swallowing

Respiratory
____ Asthma ____ Cough/wheeze ____ Shortness of breath
____ Chronic Obstructive Pulmonary Disease ____ Emphysema
___ Tuberculosis ____ Coughing up blood

Cardiovascular
____ Chest Pain ____ Palpitations ____ Heart attack
____ Shortness of breath with exertion ____ Swelling in extremities ____ Stroke
____ Heart murmur ____ Pacemaker/defibrillator ____ Valve replacement

Gastrointestinal
____ Abdominal pain ____ Nausea ____ Constipation
____ Change in appetite ____ Diarrhea ____ Vomiting

Genitourinary
____ Painful urination
____ Bloody urination
____ Discharge: penis or vagina
____ Leakage of urine ____ # of pads per day.
____ Nighttime urination _____ # of times.
____ Do you have difficulty emptying your bladder?
____ Recent urinary tract infection
____ Recent kidney infection
____ Recent prostate infection
____ Concern with sexual function

Musculoskeletal

____ Muscle Pain ____ Joint pain ____ Recent back pain
____ Chronic back pain

Neurological

____ Weakness in any part of your body ____ Numbness in any part of your body
____ Recent loss of consciousness ____ Memory loss
____ Loss of energy ____ Seizures or convulsions
____ Dizzy spells ____ Confusion

Psychiatric

____ Anxiety ____ Sleep problems
____ Stress ____ Other

Endocrine

____ Excessive thirst ____ Cold intolerance
____ Excessive hunger ____ Thyroid problem
____ Heat intolerance

Hematologic/Lymphatic

____ Anemia ____ Easy bruising/bleeding ____ Unexplained lumps

_____ _____
Patient or Guardian signature Date

_____ _____
Provider signature Date