MUA
MANCHESTER UROLOGY ASSOCIATES, PA

NEW PATIENT HISTORY FORM

Last Name ________________________ **First Name** ______________________ **Middle** ________________

Today's Date _____/_____/ ________ **Age** _______________ **Date of Birth**________/_________/_________

Phone: Home ______________________ **Work** _______________________ **Cell** ___________________________

Mailing Address: ____

Referring Physicians Name ______________________**Primary Care Physician** _______________________

Main Reason for today's visit:
____

Answers 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.

Personal Medical History: please indicate whether you have had any of the following medical problems, (Please indicate with a yes or no.)

Yes No

Heart Disease: (type) ____

Do you have cardiac stents? ____ What type? ______________________________________

If yes: When was it placed and by whom? _____________________________________

Do you have a pacemaker, mechanical or replacement valve, or other implants? _______

If yes: When was it placed and by whom? _____________________________________

Have you ever had a Myocardial Infarction (Heart Attack)? ______

If yes: When did you have the heart attack? ____________________________________

Do you experience Angina (Chest Pain)? ________

If yes: How do you manage the episode? ______________________________________

Who is your cardiologist? ____

High Blood Pressure

High Cholesterol

Diabetes (specify) type I ___ or type II ____

Thyroid Problem

Gout

Asthma/Lung Disease

Kidney disease

Kidney stones

Hepatitis A __ B __ C__

Stroke / Cerebral Vascular Accident/ Transient Ischemic Attack

Multiple Sclerosis

Parkinson's disease

Alzheimer/Dementia

Gastroesphogeal Reflux Disease (GERD)

Yes No

Gastrointestinal disease: Crohn's Disease ______

Irritable Bowel Syndrome ______

Clostridium Difficile Colitis (C. Difficile, or C. Dif) _____

Cancer (type) ____

Who is your oncologist? _______________________________________

Back problems/Spinal Cord Injury

Joint replacement (which joint) ____________________

If yes: When was it replaced? ________ Who was the orthopedic surgeon? ________________

Cataracts

Glaucoma

Has it been recommended that you take antibiotics prior to dental or other procedures?

Surgical History:

____

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____

Allergies & reactions to medications:

Allergy:	Reaction:	Allergy:	Reaction:
____________	_______________________	______________	_______________________
____________	_______________________	______________	_______________________
____________	_______________________	______________	_______________________
____________	_______________________	______________	_______________________
____________	_______________________	______________	_______________________

Please list the medications and/or over-the-counter, herbal supplements, vitamins, or homeopathic intake. Medications: Prescriptions, Over-the-counter, Herbal, Vitamins, or Homeopathic: Please include: **Anti-coagulants: (Blood Thinners) including, aspirin, coumadin, (warfarin), plavix, (clopidogrel).**

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Pharmacy Name ________________________________ Location ______________________________________

Family History: Please indicate yes or no, if your grandparents, parents, or brothers/sisters have had the following conditions:

	Yes	No		Yes	No
Alzheimer/ Dementia			Kidney Disease		
Asthma/COPD			Kidney Stones		
Chronic Obstructive Pulmonary Disease			High Cholesterol		

Family History: (Continued)

	Yes	No		Yes	No
Diabetes			Gout		
Heart Disease			Stroke		
Heart Attack			High Blood Pressure		
Cancer					

Type ____

Social History:

Cigarettes never quit (when) ___________________

Current Smoker: packs/day ____________ # of years __________________

Other tobacco yes no type_____________________ amount ______________________

Alcohol Use:

Do you drink alcohol? yes no # drinks/week ___________________

Do you drink caffeinated beverages? Please list how much every day:

Coffee ____________________________ Tea _______________________________

Soda ______________________________ Other _______________________________

REVIEW OF SYMPTOMS: Please check any **current** symptoms you have.

Constitutional

_____ Recent fevers/sweats _____ Chills _____ Unexplained weight loss/gain

_____ Change in appetite _____ Unexplained fatigue _____ Sleeping difficulty

_____ Headaches

Eyes

_____ Glaucoma _____ Cataracts _____ Glasses/Contacts?

_____ Blurring or double vision

Ears/Nose/Throat/Mouth

_____ Ear pain _____Difficulty hearing/ ringing in ears

_____ Hay fever/allergies/congestion _____Trouble swallowing

_____ Persistent sore throat

Allergic/Immunologic

_____ Hay Fever/environmental allergies _____ Immunosuppressed

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

Endocrine

_____ Excessive thirst/hunger _____ Thyroid problems

_____ Heat/ Cold intolerance

REVIEW OF SYMPTOMS: (Continued)

Gastrointestinal

_____ Abdominal pain _____ Nausea _____ Vomiting
_____ Change in appetite _____ Diarrhea/Constipation

Cardiovascular

_____ Chest pain _____ Palpitations _____ Heart attacks
_____ Shortness of breath with exertion _____ Swelling in extremities _____ Stroke
_____ Heart murmur _____ Pacemaker/defibrillator _____ Valve replacement

Skin/Breast/Chest

_____ Rash _____ Non healing lesions

Respiratory

_____ Asthma _____ Cough/wheeze _____ Shortness of breath
_____ Chronic Obstructive Pulmonary Disease (COPD) _____ Emphysema
_____ Tuberculosis _____ Coughing up blood

Musculoskeletal

_____ Muscle pain _____ Joint Pain _____ Recent back pain
_____ Chronic back pain

Hematologic/Lymphatic

_____ Anemia _____ Easy bruising/bleeding _____ Unexplained lumps

Psychiatric

_____ Anxiety/stress _____ Sleep problems
_____ Depression _____ Other

Genitourinary

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

Mobility:

Yes No

Are you able to walk independently?

Do you use an assistive device? ____ Cane _____ Walker ____ Wheelchair ____Scooter

If yes, can you stand and pivot? __________________

____ _________________________
Patient or Guardian Signature Date

____ _________________________
Providers Signature Date