TriCounty Urology

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NEW PATIENT PROFILE

PLEASE FILL OUT THIS QUESTIONNAIRE.
ASK THE STAFF IF YOU NEED HELP.

Date ___/____/___ DOB ____/___/_____

Patient ________________________________

SSN ___________________________________

Mailing Address _______________________

City _____________________ Zip ________

Home Phone _________________________

Cell Phone ___________________________

Your Employer ____Work phone _____________________
Marital Status ____
Spouse/Guardian's Name___________________________________Spouse Work phone _____________
Name of your Family Doctor _____________________________________ City ____________________
Name of Doctor that sent you ____________________________________ City ____________________
In Case of Emergency Call (other than above) ____

INSURANCE INFORMATION

Are you, the patient, also the insurance policyholder? If yes, skip next section. If no, please fill out:
Policyholder's name/address ____
Policyholder's SSN_______________________________________ DOB ________________________
Policyholder's relationship to you ____
Policyholder's employer ____

What is your preferred **LOCAL** pharmacy**?** ____
What is your preferred **MAIL ORDER** pharmacy? _______________________________________
What is your Email Address? ____

What is your preferred language? English Spanish Other:_________________________
What is your race? African American Hispanic Caucasian Other:___________________
What is your ethnicity? Hispanic/Latino Non Hispanic/Latino Other:___________________

I attest that the information above is correct to the best of my knowledge.
I acknowledge that I have given this office the right to file with my insurance for payment for the services rendered.
I agree to pay any balance remaining on the account after my insurance has paid or denied payment (insurance co-payment, if applicable, is due at the time of the office visit).

At times, it is necessary for our physicians to obtain the patient's medication history that is available at participating pharmacies. I consent to allow access to all my prescription history to my physicians.

Signature ____

NAME____ DOB_________________

What problem(s) has brought you here to see the Doctor?

____

____

How tall are you? _____ feet _____ inches

Do you take any MEDICATIONS or PILLS? Include over-the-counter drugs

Medicine or Pill Name	Size/Dose (ex. 50 mg)	How many per day	Why do you take this?

Do you have any ALLERGIES to medications, contrast/dye, or foods? Please list below

Medicine, Food, etc.	What happens if you take or eat this?

NAME______________________________________ DOB________________

Do you have any MEDICAL PROBLEMS or ILLNESSES? Please check below

- None
- Anemia
- Anxiety
- Asthma
- Atrial Fibrillation
- Autoimmune disease
- Sleep apnea
- Heart disease
- Cancer of breast
- Cancer of colon
- Cancer of lung
- Cancer of prostate
- Cancer of ovary
- Cancer of uterus
- Cancer of cervix
- Congestive heart failure
- Crohn's disease
- Cirrhosis of liver
- COPD/emphysema
- Depression
- Diabetes, childhood
- Diabetes, adult
- Diverticulitis
- Diverticulosis
- Blood clot in legs
- Reflux/heartburn
- Glaucoma
- Hepatitis
- High cholesterol/lipids
- High blood pressure
- High thyroid
- Low thyroid
- Kidney stones
- Heart attack
- Arthritis
- Osteoporosis
- Parkinson's disease
- Pulmonary Embolus
- Circulation problems
- Kidney failure
- Rheumatoid arthritis
- Stroke
- Tuberculosis

•Other____
____

Have you ever had any SURGERIES or PROCEDURES? Please check below

- None
- Amputation
- Appendectomy
- Back surgery-neck
- Back surgery-mid back
- Back surgery-low back
- Breast augmentation
- Breast reduction
- Tubes tied for birth control
- Caesarian section
- Open heart surgery
- Carotid surgery
- Carpal tunnel repair
- Cataracts
- Gallbladder removal
- Colon removal
- Brain surgery
- Kidney stone lithotripsy
- Gastric bypass
- Hemorrhoidectomy
- Hernia repair-groin
- Hernia repair-abdominal
- Hip replacement
- Hysterectomy-abdominal
- Hysterectomy-vaginal
- Knee scope
- Knee replacement
- Laparoscopy
- Mastectomy
- Kidney removal
- Ovary removal
- Pacemaker
- Prostate removal, complete
- Shoulder scope
- Shoulder rotator cuff
- Stents in heart
- Tonsillectomy
- Thyroid removal
- Bladder tumor removal
- Prostate surgery (scope)
- Kidney stone removal/stent
- Bladder for incontinence
- Heart valve replacement
- Vasectomy

•Other____
____

NAME_______________________________________ DOB________________

Do any illnesses run in your immediate FAMILY? (Mother, Father, Brother, Sister, Son, Daughter)

• None • Unknown Why? ___________________________

• Anesthetic complications Who? _________________________________
• Asthma Who? _________________________________
• Cancer of cervix Who? _________________________________
• Cancer of colon Who? _________________________________
• Cancer of breast Who? _________________________________
• Cancer of lung Who? _________________________________
• Cancer of ovary Who? _________________________________
• Cancer of prostate Who? _________________________________
• Cancer of uterus Who? _________________________________
• Other cancers Who? _________________________________
• COPD/emphysema Who? _________________________________
• Diabetes Who? _________________________________
• Heart disease Who? _________________________________
• High cholesterol Who? _________________________________
• High blood pressure Who? _________________________________
• Kidney disease Who? _________________________________
• Stroke Who? _________________________________

•Other____
____

NAME_______________________________________ DOB________________

Do you currently smoke? Yes ___ No___
If yes, how Much? _____________________________
When did you start? ____________________________
Did you smoke in the past? Yes ___ No___
If yes, when did you quit? ______________________
When did you start? ____________________________
How much did you smoke? _____________________
Do you use other forms of tobacco? Yes ___ No
If yes, what? _________________________________

Do you drink alcohol? Yes ___ No ___
If yes, what do you drink? ___________________________________
How many drinks per day _________ per week ________________
Do you perceive your drinking to be problematic? Yes ___ No___
Do you or others feel you should cut down? Yes ___ No___
Do you feel guilty about drinking? Yes ___ No___
Do you need an eye opener in the morning? Yes ___ No___

Do you use any illegal drugs? Yes ___ No___
If yes, what? _________________________________
Do you exercise regularly? Yes ___ No___
If yes, what kind? ______________________________
How many days per week? ______________________

The next set of questions is for patients age 50 and older only:

Have you ever been screened for colon cancer (colonoscopy, flexible sigmoidoscopy, or blood in stool check)? If yes, what and when? ____
What were the findings? ____
If no, why not? ____
Do you get the Flu Vaccine?
If yes, when was your last one? ____
If no, why not? ____
Do you get the Pneumonia Vaccine (age 65 and older)?
If yes, when was your last one? ____
If no, why not? ____

The next set of questions is for females only:

Have you had a mammogram in the past two years (ages 50 to 69)?
If yes, when? ____
If no, why not? ____
Have you had a test to check for osteoporosis (ages 65 and older)?
If yes, when was your last one? ____
If no, why not? ____
Do you have urinary incontinence (leakage of urine)? Yes ___ No___

NAME____ DOB_________________

REVIEW OF SYSTEMS

Do you have or have you ever had?	Yes	No	Don't know	Describe
Recent fever or chills				
Sweats				
Fatigue or weakness				
Loss of appetite				
Weight loss				
Vision loss				
Blurring of vision				
Double vision				
Eye pain				
Sensitivity to light				
Hearing loss				
Ear pain				
Ringing in ears				
Nose bleeds				
Nasal congestion				
Sore throat				
Hoarseness				
Chest pain or angina				
Irregular heartbeat/racing heart				
Fainting				
Shortness of breath with activity				
Swelling of ankles/legs				
Shortness of breath				
Cough				
Excessive sputum				
Blood in sputum				
Wheezing				
Nausea				
Vomiting				
Diarrhea				
Constipation				
Abdominal pain/cramping				
Blood in stool				
Vomiting blood				
Jaundice				
Indigestion/heartburn				
Back pain				
Joint pain				
Muscle cramps				
Muscle weakness				
Arthritis				
Sciatica				

NAME____ DOB_________________

Do you have or have you ever had?	Yes	No	Don't know	Describe
Rash				
Itching				
Dry skin				
Paralysis				
Numbness				
Seizures				
Tremors				
Vertigo				
Frequent headaches				
Cold intolerance				
Heat intolerance				
Excessive thirst				
Excessive hunger				
Abnormal bruising				
Abnormal bleeding				
Enlarged nodes				
Hay fever/seasonal allergies				
Persistent infections				
HIV exposure				
Depression				
Anxiety				
Memory loss				
Leakage of urine				
Pain with urination				
Blood in urine				
Frequent need to urinate				
Waking up at night to urinate				
Difficulty passing urine				
Kidney stones				

FOR MEN ONLY

Do you have or have you ever had?	Yes	No	Don't know	Describe
Discharge from penis				
Genital sores/sexually transmitted disease				
Decreased libido				
Problems with erections				
Testicle pain				
Testicle lump				

FOR WOMEN ONLY

Do you have or have you ever had?	Yes	No	Don't know	Describe
Vaginal discharge				
Vaginal bleeding				
Do you have any children? How many?				
Could you be pregnant now?				