PROVIDING UROLOGIC CARE & SURGERY
A Division of 21st Century Oncology, LLC

New Patient History Form

Patient ID #: ______________

Name ______________________ (Last), ______________________ (First) **Date** _____/_____/_______

Date of Birth ____/____/_____ **Age** _______ **Email Address:** ________________________

Referring Physician's Name: _____________ **Primary Care Physician:** _______________

Main Reason for today's visit: ____

Please give detailed information about the ***Present Problem*** (e.g. When did it start? How long does it last? Does anything make it better or worse? Severity? Is it constant or variable? Location? Etc.):

Any ***Other Urologic Problems***: (Please check those that apply):

- ☐ Urinary Frequency (How many hours can you go without urinating? __________ hours),
- ☐ Urgency to urinate (How many times do you urinate in 24 hours? ___________/ day)
- ☐ Nocturia (About how many times do you have to get out of bed to urinate while sleeping?) ___________
- ☐ Incontinence (Do you use pads or change underwear?) _________ How many? _________/ day

☐ Decreased Stream	☐ Retention or Sensation of Incomplete Emptying	
☐ Post Void Dribbling	☐ Hesitancy	☐ Dropped Bladder
☐ Urinary Burning/Pain	☐ Frequent Urinary Infections	☐ Blood in Urine
☐ Sexual Problems/Impotence	☐ Sexually Transmitted Disease	☐ Bladder
☐ Kidney Stones	☐ Prostate Problems	☐ Other

Personal Medical History:

☐ Heart Disease	☐ High Blood Pressure	☐ Heart Valve Disease
☐ Diabetes	☐ Hepatitis	☐ Gout
☐ Bleeding Problems	☐ Stroke	☐ Irritable Bowel
☐ Asthma/Emphysema	☐ T.B.	☐ Thyroid Disease
☐ HIV	☐ Cancer	☐ Other

Surgical History and/or Hospitalizations: (Please list approximate date)

Surgery	Month/Year	Surgery
☐ Hernia	_______________	_______________
☐ Vasectomy	_______________	_______________
☐ Appendectomy	_______________	_______________
☐ Other	_______________	_______________

Last **PSA** (Prostate Cancer Screening Blood Test) Test Result: ______________ Date: ______________

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Social History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Do you now or have you ever smoked? ☐ Yes ☐ No If Yes, when did you quit? Date: _____________

How many packs per day? _______________ Smoking for how many years? __________

How much Beer, Wine, or Alcohol do you drink per week? __________ Recreational drugs? ☐ Yes ☐ No

What kind of work do you do know or did you do? ____

Exposure to chemicals, toxins, fumes, radiation or excessive heat (regular use of Hot Tub, Jacuzzi, Sauna or Whirlpool)? ____

How much Coffee, Tea, Iced Tea, or Caffeinated Beverages? _______ How much water do you drink? ________

Do you eat a lot of spicy, pickled or acidic foods? ☐ Yes ☐ No

Family History:

List serious illnesses that may run in your family (e.g. Porstate Cancer, Kidney Stones, Kidney Disease, Diabetes, Cancer, Cystic Fibrosis, Etc.).

Mother ______________________ Brother/Sister ____________________ Other ________________________

Father _______________________ Brother/Sister ____________________ Other ________________________

Review Of Systems

(Please check Yes or No to All Questions Below)

Constitutional Symptoms

Fever ☐ Yes ☐ No

Chills ☐ Yes ☐ No

Headache ☐ Yes ☐ No

Weight Loss ☐ Yes ☐ No

Eyes

Blurred Vision ☐ Yes ☐ No

Double Vision ☐ Yes ☐ No

Pain ☐ Yes ☐ No

Allergic / Immunologic

Hay Fever ☐ Yes ☐ No

Multiple Allergies ☐ Yes ☐ No

Neurological

Tremors ☐ Yes ☐ No

Dizzy Spells ☐ Yes ☐ No

Numbness / Tingling ☐ Yes ☐ No

Weakness ☐ Yes ☐ No

Endocrine

Excessive Thirst ☐ Yes ☐ No

Intolerant to Heat/Cold ☐ Yes ☐ No

Excessive Fatigue ☐ Yes ☐ No

Gastrointestinal

Abdominal Pain ☐ Yes ☐ No

Constipation/Diarrhea ☐ Yes ☐ No

Nausea/Vomiting ☐ Yes ☐ No

Indigestion/Heartburn ☐ Yes ☐ No

Hemorrhoids ☐ Yes ☐ No

Cardiovascular

Chest Pain ☐ Yes ☐ No

Varicose Veins ☐ Yes ☐ No

Poor Circulation ☐ Yes ☐ No

Ankle Swelling ☐ Yes ☐ No

Skin

Skin Rash ☐ Yes ☐ No

Boils ☐ Yes ☐ No

Persistent Itch ☐ Yes ☐ No

Musculoskeletal

Joint Pain ☐ Yes ☐ No

Neck Pain ☐ Yes ☐ No

Back Pain ☐ Yes ☐ No

Ear/Nose/Throat/Mouth

Ear Infection ☐ Yes ☐ No

Sore Throat ☐ Yes ☐ No

Sinus Problems ☐ Yes ☐ No

Gynecological (Females Only)

No. Of Pregnancies ___________

No. of Live Births ___________

C-Section ☐ Yes ☐ No

Hysterectomy ☐ Yes ☐ No

(If yes, please check one that applies)

☐ Abdominal ☐ Vaginal ☐ Total

☐ Partial ☐ Ovaries Removed ☐ Other

Respiratory

Wheezing ☐ Yes ☐ No

Frequent Cough ☐ Yes ☐ No

Shortness of Breath ☐ Yes ☐ No

Hematologic/Lymphatic

Swollen Glands ☐ Yes ☐ No

Blood Clotting Problem ☐ Yes ☐ No

Mumps ☐ Yes ☐ No

Psycologic

Do you feel severely depressed? ☐ Yes ☐ No

Anxiety/Excessive nervousness? ☐ Yes ☐ No

Other

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Height: _____________ **Weight:** _______________ **BP** **P** **R**

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