UROLOGY SPECIALISTS OF ATLANTA

5673 PEACHTREE DUNWOODY ROAD – SUITE 910 – ATLANTA, GA 30342
PHONE: (404) 255-3822 FAX: (404) 255-0495

RETURN PATIENT INTAKE FORM

Name: _____ DOB: ____/____/____ APPT Date ____/____/____

Your Primary Doctor:_____ Your Referring Doctor_____

PLEASE COMPLETE ALL QUESTIONS / SECTIONS OF THIS FORM

What would you like to discuss with the doctor today? _____
How long has the issue been going on? _____
When does it occur? _____
How severe is it? _____
Has anything made it better/worse? _____

DO YOU ***CURRENTLY*** HAVE ANY OF THE FOLLOWING PROBLEMS? (PLEASE CHECK YES/NO)

CONSTITUTIONAL:

	Yes	No
Fever	[ ]	[ ]
Shaking Chills	[ ]	[ ]
Unintentional Weight Loss	[ ]	[ ]

EYES:

Unexplained Blurry Vision	[ ]	[ ]

CARDIOVASCULAR:

Chest Pains	[ ]	[ ]
Palpitations	[ ]	[ ]

RESPIRATORY:

Wheezing	[ ]	[ ]
Shortness of Breath	[ ]	[ ]

GASTROINTESTINAL:

Constipation	[ ]	[ ]
Straining for Bowel Movement	[ ]	[ ]
Leakage of Stool	[ ]	[ ]

ENDOCRINE:

Hot Flashes	[ ]	[ ]
Hot / Cold Intolerance	[ ]	[ ]

HEMATOLOGIC:

Abnormal Bruising	[ ]	[ ]

MUSCULOSKELETAL:

Bone Pain	[ ]	[ ]
Back Pain	[ ]	[ ]

NEUROLOGICAL:

	Yes	No
Tremors	[ ]	[ ]
Difficulty Walking	[ ]	[ ]
Numbness/Tingling of Legs	[ ]	[ ]

GENITOURINARY:

Weak Stream of Urine	[ ]	[ ]
Pushing to Urinate	[ ]	[ ]
Incomplete Bladder Emptying	[ ]	[ ]
Frequent Urination Daytime	[ ]	[ ]
Frequent Urination Nighttime	[ ]	[ ]
Urgency of Urination	[ ]	[ ]
Leakage of Urine	[ ]	[ ]
Burning with Urination	[ ]	[ ]
Lower Abdominal Pain	[ ]	[ ]
Flank Pain	[ ]	[ ]
Blood in the Urine	[ ]	[ ]
Recurrent Bladder Infections	[ ]	[ ]

GENITOURINARY *(For Men Only)*:

Erection Problems	[ ]	[ ]
Ejaculatory Problems	[ ]	[ ]
Infertility	[ ]	[ ]

GENITOURINARY (*For Women Only*):

Pain with Intercourse	[ ]	[ ]
Vaginal Bulge Sensation	[ ]	[ ]
Pelvic Pain	[ ]	[ ]

Last Menstrual Period (Date): ____/____/____

SINCE YOUR LAST VISIT TO UROLOGY SPECIALISTS OF ATLANTA HAVE YOU?

1) Been Diagnosed with Any New Medical Condition? [ ] Yes [ ] No

If Yes, Please Provide Details:

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2) Had Any Surgeries or Procedures? [ ] Yes [ ] No

If Yes, Please Provide Details:

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3) Been Hospitalized? [ ] Yes [ ] No

If Yes, Please Provide Details:

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4) Smoking History:

[ ] Current Every Day Smoker
[ ] Current Some Day Smoker
[ ] Former Smoker
[ ] Never Smoker