West Shore Urology, P.L.C.

NEW PATIENTS
FEMALE

Today's Date: _____

Name: _____ **DOB:** _____

Sex: _____ **Height:** _____ **Weight:** _____

Preferred Pharmacy: _____ **Referring Provider:** _____

What is your primary complaint?

_____

_____

How long have you had this problem?

_____

MEDICATIONS Currently taking with dosages:

_____

Do you take blood thinners?

_____

ALLERGIES Updates/Changes/Reaction:

_____

Review of Systems:

Have you experienced any of the following within the last 30 days? (circle Yes / No)

Constitutional
Chills No / Yes
Fever No / Yes
Weight Loss No / Yes

HEENT
Blurred Vision No / Yes

Respiratory
Short of Breath No / Yes

Cardiovascular
Chest Pain No / Yes

Gastrointestinal
Abdominal Pain No / Yes
Blood in Stool No / Yes
Constipation No / Yes
Diarrhea No / Yes
Nausea No / Yes
Vomiting No / Yes

Genitourinary
Painful Urination No / Yes
Blood in Urine No / Yes
Urinary Frequency No / Yes
Urinary Urgency No / Yes
Urinary Incontinence No / Yes
Unable to Empty Bladder No / Yes

Reproductive
Vaginal Discharge (female) No / Yes

Psych
Anxiety No / Yes
Depression No / Yes

Integumentary
Rash No / Yes

Musculoskeletal
Back Pain No / Yes

Hematologic
Easy Bleeding No / Yes
Swollen Lymph Nodes No / Yes

Past Medical:

In addition to what is listed above, please check all, if any, that apply below:

- Angina ☐
- Asthma ☐
- COPD ☐
- Atrial Fibrillation ☐
- Diabetes Type I or II ☐
- Heart Attack (MI) ☐
- Hepatitis A, B, C ☐
- High Blood Pressure ☐
- Irreg./Rapid Heartbeat ☐
- Kidney Disease ☐
- Kidney Stones ☐
- Liver Disease ☐
- Stroke ☐
- Thyroid Disease ☐
- Reflux (Esophageal) ☐
- Glaucoma ☐
- Bleeding Disorder ☐
- Type _____
- Chronic Diarrhea ☐
- Chronic Constipation ☐
- Depression ☐
- Hernia Type _____ ☐
- Irritable Bowel Syndrome ☐
- Urinary Tract Infection ☐
- Sleep Apnea ☐
- Cancer Type _____ ☐
- Muscle Aches ☐
- HIV/AIDS ☐
- Vascular Type _____ ☐
- Pacemaker ☐

Surgery:

		Year
Gallbladder	☐	_____
Heart Surgery Type: _____	☐	_____
ESWL (Lithotripsy)	☐	_____
Cystocele	☐	_____
Hysterectomy	☐	_____
Please Specify: _____		
Nephrectomy (Kidney Removal)	☐	_____
Rectocele	☐	_____
Joint Surgeries	☐	_____
Please Specify: _____		

Surgery:

		Year
C-Sections	☐	_____
Vaginal Births	☐	_____
Sling Surgery	☐	_____
Spleen Removed	☐	_____
Urinary Sphincter	☐	_____
Tonsils Removed	☐	_____
Appendix Removed	☐	_____
Adnoids Removed	☐	_____
Vascular	☐	_____
Type _____		

Other Medical Problems/Other Surgeries:

_____

_____

_____

_____

_____

Family History:

		Family Member
Bladder Cancer	☐	_____
Kidney Cancer	☐	_____
Diabetes	☐	_____
Prostate Cancer	☐	_____
Kidney Stones	☐	_____

Other Family History:

Mother _____

Father _____

All alive and well _____

Social History:

Do you currently use tobacco? No / Yes Type: _____ Amount per day: _____ Age Started: _____

Have you ever used tobacco? No / Yes Type: _____ Age Stopped: _____

Alcohol Use: No / Yes / Former Type: _____ How Often: _____

Caffeine Use: No / Yes / Former Type: _____ How Often: _____

I certify that the information on this form is correct to the best of my knowledge.

Patient's Signature: _____ Today's Date: _____