Tennessee UROLOGY®

New Patient Information

NAME_____ **DATE** _____

CHIEF COMPLAINT

Reason for visit_____

PRE RELEASE CONTACT PERMISSION

Medical Contact Permission

Is there someone we have permission to contact or share medical information with on the Patient's behalf?

☐ Yes ☐ No

The Patient gives permission to the doctor and staff to release information to (enter first, last name and relationship):

1. _____
2. _____

HIPAA Confirmation

May we disclose personal health information with the Patient's emergeny contact

☐ Yes ☐ No

Medical Permission Contact

Enter the first and last name of the emergency contact person

_____

Enter the emergency contact's main phone number

_____

Enter the emergency contact's relationship to the patient

_____

NURSING HOME CONFIRMATION

Are you a resident in a Nursing Home, Skilled Nursing Facility or participate with Chimes?

☐ Nursing Home ☐ Skilled Nursing Facility ☐ Chimes ☐ None

REVIEW OF SYSTEMS

Please select all that apply (General, Skin, HEENT, Respiratory, Cardiac)

☐ None ☐ Weight Gain ☐ Weight Loss ☐ Fatigue ☐ Rash
☐ Hearing Loss ☐ Frequent Cough ☐ Shorntess of Breath ☐ Wheezing
☐ Irregular Heartbeat ☐ Chest Pain ☐ Swollen Ankles/Legs

Please select all that apply (Gastrointestinal, Musculoskeletal, Neurologic, Endocrine, Hematology)

☐ None ☐ Abominal Pain ☐ Nausea ☐ Vomiting ☐ Bone Pain ☐ Joint Pain ☐ Muscle Pain
☐ Dizziness ☐ Numbness/Weakness ☐ Tremors ☐ Excessive Thirst
☐ Blood Clots ☐ Bruise Easily ☐ Swollen Glands

NAME_____ **DATE** _____

ALLERGIES

For each allergy, select all of the following symptom that the patient experiences

	Abdominal Pain	Anaphylaxis	Chest Pain	Diarrhea	Difficulty Breathing	Difficulty Swallowing	Itching	Nausea Vomiting	Swelling	Rash Hives	Other
None											
Aspirin											
Cipro											
Codeine											
Contrast Dye											
Demerol											
Depakote											
Dilantin											
Doxycycline											
Ibuprofen											
Insulin											
Iodine											
Latex											
Levaquin											
Morphine											
Penicillin											
Seasonal Allergies											
Sulfa											
Tetracycline											
Other/Not Listed											

PAST MEDICAL HISTORY

Do you have any of the following:

☐ AICD ☐ Pacemaker ☐ None

Past and current medical conditions (please select)

☐ None ☐ Agent Orange Exposure ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Bladder Cancer
☐ Bladder Infection ☐ Bleeding Disorders ☐ Breast Cancer ☐ Cataracts ☐ Chronic Low Back Pain
☐ Blood Clots ☐ Cardiac Disorder ☐ Colitis ☐ Colon Cancer ☐ COPD ☐ Congestive Heart Faliure
☐ Coronary Artery Disease ☐ Depression ☐ Diabetes ☐ Dialysis ☐ Deficits in activities of daily living
☐ Enlarged Prostate ☐ Endometriosis ☐ Erectile Dysfunction ☐ Glaucoma ☐ Heart Attack ☐ Heart Disease
☐ Heart Murmur ☐ Hepatitis ☐ High Blood Pressure ☐ High Cholesterol ☐ HIV/AIDS ☐ HPV ☐ Infertility
☐ Ischemic Vascular Disorder ☐ Kidney Cancer ☐ Kidney Stones ☐ Kideny Disease ☐ Lupus
☐ Mitral Valve Prolpase ☐ Osteoporosis ☐ Ovarian Cancer ☐ Ovarian Cyst ☐ Overactive Bladder
☐ Peripheral Artery Disease ☐ Prostate Cancer ☐ Rheumatoid Arthritis ☐ Scleroderma ☐ Seizure Disorder
☐ Sickle Cell Anemia ☐ STD ☐ Sleep Apnea ☐ Stroke ☐ Thyroid Disease ☐ Testicular Cancer
☐ Undescended Testicle ☐ Uterine Fibroids ☐ Colitis ☐ Lupus ☐ Scleroderma ☐ Rheumatoid Arthritis

☐ Other/Not Listed _____

NAME_____ **DATE** _____

SURGERIES

Select any surgery or invasive procedure the patient had performed by another provider outside of Tennessee Urology Associates? Please select all that apply

☐ None ☐ Appendectomy ☐ Back Surgery ☐ Cardiac/Heart Bypass ☐ Cardiac Stent/Catherization
☐ Cesarean Section ☐ Colon/Bowe Surgery ☐ Colonoscopy ☐ Gall Bladder Removal ☐ Gastric Bypass
☐ Hernia Repair ☐ Hip Replacement ☐ Hysterectomy ☐ Kidney Surgery ☐ Kidney Transplant
☐ Knee Replacement ☐ Masectomy ☐ Penile Implant ☐ Prostate Biopsy ☐ Prostate Surgery
☐ Scrotum/Testicle Surgery ☐ Thyroid Surgery/Biopsy ☐ Tubal Ligation ☐ Vasectomy

☐ Other/Not Listed _____

FAMILY HISTORY

Select all that apply

	Mother	Father	Brother	Sister	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
None								
Cervical Cancer								
Uterine Cancer								
Breast Cancer								
Ovarian Cancer								
Prostate Cancer								
Bladder Cancer								
Colon Cancer								
Pancreatic Cancer								
Renal/Kidney Cancer								
Kidney Stones								
Renal/Kidney Failure								
Unknown Family History								

SOCIAL HISTORY

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

Select the option that best describes the Patients smoking status.

☐ Every day Smoker ☐ Occasional smoker ☐ Former Smoker ☐ Never Smoked

Current Smoker - How many cigarettes does the Patient smoke per day?

☐ Less than 1 pack ☐ 1-2 packs ☐ More than 2 packs

Current Smoker - How many years has the Patient been smoking?

☐ One year or less ☐ 1-5 years ☐ 5-10 years ☐ 10 years or more

Past Smoker - How many cigarettes did the Patient smoke per day?

☐ Less than 1 pack ☐ 1-2 packs ☐ More than 2 packs

Past Smoker - How many years did the Patient smoke?

☐ One year or less ☐ 1-5 years ☐ 5-10 years ☐ 10 years or more

Enter the year when the Patient quit smoking _____

NAME_____ **DATE** _____

How often does the Patient drink alcohol?

☐ Daily ☐ Weekly ☐ Rarely ☐ Never

How many drinks do you have per day?

☐ 4 Drinks or less per day ☐ 5 drinks or more per day

How many drinks do you have per episode?

☐ 4 Drinks or less per episode ☐ 5 drinks or more per episode

Does the patient currenlty use recreational drugs?

☐ Yes ☐ No

Please select all drugs used

☐ Cocaine ☐ Heroin ☐ Crack Cocaine ☐ Downers (xanax, valium, etc) ☐ Marijuana

☐ IV Drugs ☐ Uppers (meth, adderall, ritalin, etc) ☐ Other/Not Listed

EXERCISE

How many days a week does the Patient exercise?

☐ Zero ☐ One ☐ Two ☐ Three ☐ Four ☐ Five

CHILDREN

Do you have children?

☐ Yes ☐ No

How many children do you have?_____

MEDICATIONS

Is the patient taking any medications, including vitamins and over the counter drugs?

☐ Yes ☐ No

List Medications and Dosages (example – Motrin 800 mg three times a day). If you have a list of medications, you may provide it to the front desk staff instead of listing.

Medication	Dosage

HEALTH MAINTENANCE

Has the Patient had a Colonoscopy in the last 9 years? ☐Yes ☐ No

If the Patient has had a Colonoscopy in the last 9 years, what year was it? Enter Year_____

What is the reason that the patient has not had a colonoscopy?

☐ Total Colectomy ☐ Recent Flex Sigmoidoscopy ☐ Recent Fecal Occult

☐ Unaware of Need ☐ Unaware of Need ☐ Other