



Urology – New Patient Intake Form

Name: _____ DOB: ____/____/____ Age: _____

What is the reason for your visit today? _____

When did you first notice the problem? _____

Does anything help or make the problem worse? _____

Is it constant? ☐ Or come and go? ☐ Severity on a scale from 1 – 10 (10 being most severe) _____

PREFERRED PHARMACY: _____

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes ____x per day ☐ Former ____years

Do you use smokeless tobacco? ☐ No ☐ Yes ____x per day ☐ Former ____years

Marijuana? ☐ No ☐ Yes ☐ Former

Methamphetamine? ☐ No ☐ Yes ☐ Former

Caffeine: ☐ No ☐ Yes ____x a day

Alcohol: ☐ No ☐ Yes ☐ Former ____oz per day

ALLERGIES: Do you have any other allergies?

Medication	Food	Environmental

Are you allergic to latex? ☐ No ☐ Yes

Are you allergic to Betadine/Iodine? ☐ No ☐ Yes

Medication Name:	Dosage:	Frequency:	Reason:

Family History:

Family Member	Age	Illness

Infections:

- ☐ Hepatitis **A B C** (please circle) ☐ HIV ☐ MRSA ☐ Scabies ☐ Tuberculosis ☐ Body Lice ☐ C. Diff
☐ Other: _____

Surgical History:

Date:	Type:	Hospital: