BRIGHAM AND WOMEN'S Health Care

Place Patient Label Here:

DIVISION OF UROLOGICAL SURGERY

New Patient Intake Form **Date:**

I. Demographic Information

Name: _____ Date of Birth: _____ Age: _____ BWH MRN # _____

Home Address: _____

Home phone: _____ Cell phone: _____

Email: _____

II. Care Information – Please list complete names and addresses of physicians (VERY IMPORTANT)

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Referring Physician (if different from PCP): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Other Physicians (if different from above): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Pharmacy: _____ Address: _____

Phone: _____ Fax: _____ City: _____ State: _____ Zip: _____

III. Reason for Visit- Chief Complaint (History of Present Illness)

Please describe the major problem that brings you in today to see an urologist:

_____

_____

Is this visit related to worker's compensation? (Circle one) Yes No

Is this visit related to any legal actions? (Circle one) Yes No

If this problem is a result of an accident, when did the accident occur? _____

IV. Surgical History

Please list all operations you have had: Date:

_____ _____

_____ _____

_____ _____

Have you ever had a stent placed in your heart? (Circle one) Yes No

V. Social History

Occupation: _____ Marital Status: _____ Number of Children: _____

Hobbies: _____

Do you smoke cigarettes? _____ If so, how many packs a day? _____

At what age did you start? _____ If applicable, at what age did you stop? _____

Do you drink alcohol? _____ If yes, how much daily? _____

At what age did you start? _____ If applicable, at what age did you stop? _____

Do you use recreational drugs? _____ Type? _____

Do you exercise regularly? (Circle one) Yes No How frequently? _____

Height: _____ Weight: _____

VI. Medical History Please list all active medical conditions including:
Hypertension, Diabetes, Coronary Artery Disease, Lung Disease and Kidney Disease Duration:

_____ _____

_____ _____

_____ _____

Females: Are you, or could you be pregnant? (Circle one) Yes No

Please list **all MEDICATIONS** you take *routinely*, prescribed or over-the-counter, along with the dosages:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list **all ALLERGIES** and sensitivities (e.g. medication, foods, latex, iodine, etc.)

_____

_____

_____

Are you taking any blood-thinning medications? (Circle one) Yes No (If yes, please indicate below)

- ☐ Aspirin or aspirin-containing medications
- ☐ Anti-inflammatory medications
- ☐ Plavix
- ☐ Coumadin
- ☐ Fish Oil
- ☐ Other: _____

VII. Family History Do you have a family member affected with:

Condition	Yes	No	Type/Affected Relative	Condition	Yes	No	Type/Affected Relative
Cancer (Non-Genitourinary)	☐	☐	_____	Kidney Disease	☐	☐	_____
Testicular Cancer	☐	☐	_____	Bleeding/clotting	☐	☐	_____
Prostate Cancer	☐	☐	_____	Heart Disease	☐	☐	_____
Bladder Cancer	☐	☐	_____	High Cholesterol	☐	☐	_____
Kidney Cancer	☐	☐	_____	Hypertension	☐	☐	_____
Kidney Stones	☐	☐	_____	Diabetes	☐	☐	_____
Other conditions	☐	☐	_____				

Write other conditions: _____

VIII. Review of Symptoms Do you currently, or have you had a problem with:

	Yes	No
Constitutional	☐	☐
Weight loss	☐	☐
Prolonged fevers	☐	☐
Cardiovascular		
High blood pressure	☐	☐
Angina/ chest pain/ heart attack (MI)	☐	☐
Heart valve problem/ irregular pulse (Arrhythmia)	☐	☐
Respiratory		
Asthma	☐	☐
Emphysema	☐	☐
Prolonged cough or shortness of breath	☐	☐
Gastrointestinal		
Ulcers	☐	☐
Hepatitis	☐	☐
Constipation	☐	☐
Genitourinary		
Bloody urine	☐	☐
Leaking urine/ poor urinary control	☐	☐
Poor erectile/ sexual function	☐	☐
Stones	☐	☐
Endocrine		
Diabetes	☐	☐
Gout	☐	☐
Thyroid abnormality	☐	☐

	Yes	No
Hematology		
Excessive bleeding with surgery	☐	☐
Anemia	☐	☐
Blood clots in legs/ lungs	☐	☐
Musculoskeletal		
Prolonged back pain	☐	☐
Artificial (implanted) joints	☐	☐
Neurologic		
Strokes/"mini-stroke" (TIA)	☐	☐
Parkinson's disease	☐	☐
Alzheimer's disease or confusion	☐	☐
Multiple Sclerosis (MS)	☐	☐
Seizures (epilepsy)	☐	☐
Spinal cord injury	☐	☐
Eyes		
Glaucoma	☐	☐
Vision changes	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Immunologic		
Lupus	☐	☐
HIV/ AIDS	☐	☐
Skin		
Rashes	☐	☐
Boils or infections	☐	☐

URINARY SYMPTOM SCORE						
	None at all	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
1. INCOMPLETE EMPTYING Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. FREQUENCY Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. INTERMITTENCY Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. URGE TO URINATE Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 or more times**
7. URINATING AT NIGHT Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5
Symptom Score: 1-7 Mild, 8-19 Moderate, 20-35 Severe	Total: _____					

Rate the bothersomeness of your symptoms by circling the number below that best describes your feelings.

BOTHER SCORE DUE TO URINARY SYMPTOMS							
	Delighted	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
BOTHERSOMENESS OF URINARY SYMPTOMS How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

X. Do you have a Health Care Proxy? (Circle one) Yes No

If yes, please list: _____

If no, and you would like more information, please ask our receptionist.

The information on this form is accurate to the best of my knowledge:

_____ _____

Patient Signature Date completed

I have reviewed the above information with the patient:

_____ Clinical ID # | | | | | | _____

Physician Signature Date reviewed