MidLantic UROLOGY
The Bryn Mawr Urology Group

PATIENT INTAKE SHEET

Date: _____

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Race: W☐ B☐ Other _____ Ethnicity: Hispanic & Latino☐ Other _____

Language: English☐ Spanish☐ Italian☐ Chinese☐ Korean☐ Other _____

* The information above is requested as part of a U.S. Government initiative, not The Bryn Mawr Urology Group / division of MU.

My Main Problem(s) is/are:

☐ Leak Urine ☐ Blood in urine ☐ Dropped Bladder ☐ Bladder Pain
☐ Kidney Stones ☐ Bladder Cancer ☐ Overactive Bladder ☐ Interstitial Cystitis
☐ Bladder Infection ☐ Other _____

When did the problem begin: _____

My Other Medical Problem(s) is/are:

☐ Fever ☐ Weight Loss ☐ Chills
☐ Blurry Vision ☐ Double Vision ☐ Cataracts ☐ Glaucoma
☐ Hearing Loss ☐ Sore Throat ☐ Sinusitis ☐ Migraines
☐ Angina ☐ High Blood Pressure ☐ Chest Pains ☐ Irregular Heartbeat
☐ Problems with Heart Valves ☐ Rheumatic Fever
☐ Short of Breath ☐ Chronic Cough ☐ Wheezing ☐ Emphysema
☐ Abdominal Pain ☐ Nausea/Vomiting ☐ Bloody / Dark Stools ☐ Change in Bowels
☐ New Skin Lesion ☐ Changes in hair ☐ Changes in nails ☐ Breast Lumps
☐ Area of Numbness ☐ Weakness ☐ Stroke ☐ Difficulty Walking
☐ Loss of Bowel Control ☐ Depression ☐ Difficulty Sleeping ☐ Asthma
☐ Thyroid Condition ☐ Diabetes ☐ Immune Deficiency ☐ "Hay Fever"
☐ Anemia ☐ Enlarged lymph nodes ☐ Transfusion History ☐ Urine leakage
☐ Arthritis ☐ Chronic Back Pain ☐ Chronic Neck Pain ☐ Urinary Incontinence
☐ Blood in Urine ☐ Urinary tract infection ☐ Kidney Stones

Do you have Bleeding Tendencies (Easy bleeding / bruising)? ☐ Yes ☐ No

Allergies:

☐ None ☐ Penicillin ☐ Sulfa ☐ Cipro ☐ Iodine/contrast ☐ Shellfish
☐ Other _____

Medications:

☐ None ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Advil ☐ Fish Oil ☐ Vitamin E

Please list all of your other medications: _____

_____

When was your last Flu Shot? _____ When was your last Pneumovax? _____

Surgical History:

☐ Heart Bypass ☐ Lithotripsy ☐ Gallbladder ☐ Appendectomy ☐ Cystoscopy
☐ Kidney Stone Surgery ☐ Back ☐ Hip ☐ Knee

Please list your other operations: _____

_____

When was your last Colonoscopy? _____ Where: _____

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Medical History:

☐ Diabetes ☐ Hypertension ☐ Heart Attack ☐ Heart Murmur
☐ Strokes / Neurologic Disorder ☐ Respiratory Disease ☐ Hepatitis ☐ Exposure to TB
☐ Cancer _____ ☐ Parkinson's ☐ Hernia
☐ Other _____

Family History:

Kidney Stones ☐ No ☐ Yes, whom? _____
Heart Disease ☐ No ☐ Yes, whom? _____
☐ Other: _____

Social History:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Number of Children _____

Do you smoke? ☐ **Yes** When did you start? _____ Packs Per Day _____

☐ **Not Anymore** When did you quit? _____ Packs Per Day _____
How long? _____

☐ **Never Smoked**

Do you drink alcohol? ☐ **Yes** How many drinks/day? _____
Types of alcohol: ☐ Beer ☐ Liquor ☐ Wine
Drinking Habits: ☐ Social ☐ Light ☐ Moderate

☐ **Not Anymore** When did you quit drinking? _____
How long did you drink? _____
How many drinks per day? _____

☐ **Never Drank**

How many caffeinated drinks do you have each day? _____
Have you had a Blood Transfusion? ☐ Yes ☐ No
Employment: ☐ Retired ☐ Occupation (Current or Previous) _____

☐ Living Will ☐ Advance Directive

IS THERE ANY OTHER INFORMATION YOU FEEL IS IMPORTANT TO SHARE WITH US, NOT LISTED ABOVE? _____

_____

I certify to the best of my knowledge that all of the information listed above is true and correct:

Patient's Signature: _____