UROLOGY CARE OF CENTRAL NEW JERSEY, P.A.

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New Patient History Form

Date:

Referring Physician:

Patient Name:

Patient Age:

Email Address:

Reason for visit:

I am allergic to:

Medications I am Currently Taking
(include over-the-counter and herbal medications):

Name of Medicine	Dosage	How often taken

Surgeries I Have Had:

Type of Surgery	When

Males Only:

Date last PSA done

Last PSA results

Date last prostate exam

History of prostate infections ☐ Yes ☐ No

Females Only:

Date of last menstrual period

Number of pregnancies

Number of live births

Family History:

Diabetes ☐ Yes ☐ No

Heart Attack ☐ Yes ☐ No

Hypertension ☐ Yes ☐ No

Prostate Cancer ☐ Yes ☐ No

Other

Social History:

Alcohol ☐ Yes ☐ No

Coffee/Tea/ Carbonated Drinks ☐ Yes ☐ No

Smoking ☐ Yes ☐ No

Past Medical History:

Angina (chest pain)	☐ Yes ☐ No
Arthritic Joints	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Inflammatory Bowel Disease	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Pacemaker Placement	☐ Yes ☐ No
Peptic Ulcer Disease	☐ Yes ☐ No
Pulmonary Emboli (Blood clot in Lung)	☐ Yes ☐ No
Sickle Cell Trait/ Disease	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Use of Aspirin	☐ Yes ☐ No
Use of Blood Thinners (Coumadin)	☐ Yes ☐ No
Weight Loss	☐ Yes ☐ No
Other	

Urinary History:

Back pain? ☐ Yes ☐ No

Blood in urine? ☐ Yes ☐ No

Burning or pain while voiding? ☐ Yes ☐ No

Do you leak urine? ☐ Yes ☐ No

Frequency? ______

History of Kidney Stones? ☐ Yes ☐ No

History of Urinary Tract Infections? ☐ Yes ☐ No

Number of Night Time Urinations? ______

Urgency? ☐ Yes ☐ No