NEW PATIENT INTAKE (MALE)

First Name	MI	Last Name	Medical Record #

PREFERRED PHARMACY (Name/Address/Phone): _____

MY MAIN PROBLEMS:

☐ High PSA ☐ Enlarged Prostate ☐ Blood in urine
☐ Bladder Infection ☐ Kidney Stones ☐ Prostate Infection ☐ Urinary Incontinence
☐ Bladder Cancer ☐ Prostate Cancer ☐ Erectile Dysfunction ☐ Overactive Bladder
☐ Infertility ☐ Lump in Testicle ☐ Other: _____

ALLERGIES: ☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/Contrast

☐ Other: _____

MEDICATIONS: _____

_____

_____

SURGICAL HISTORY: ☐ **No Changes** ☐ Appendectomy ☐ Back/Hip/Knee ☐ Cystoscopy
☐ Kidney Stone Surgery ☐ Heart Bypass ☐ Gallbladder ☐ Prostate Biopsy ☐ Lithotripsy
☐ Prostate Surgery ☐ Prostate Seed ☐ Other:_____

MEDICAL HISTORY: ☐ **No Changes** ☐ Diabetes ☐ Emphysema ☐ Heart Attack
☐ Heart Murmur ☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Parkinson's
☐ Strokes ☐ Cancer: (☐ Kidney ☐ Testes ☐ Prostate ☐ Other Cancer _____)
☐ Other: _____

FAMILY HISTORY: ☐ Prostate Cancer ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

SOCIAL HISTORY: Occupation: _____ ☐ Retired
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoke: ☐ No ☐ Yes

MY SYMPTOM(S):

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat
Respiratory	☐ Wheezing	☐ Chronic Cough	☐ Shortness of Breath
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness
Hematologic/Lymphatic	☐Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History

URINARY SYMPTOM(S):

☐ Incomplete Emptying ☐ Frequency ☐ Intermittency ☐ Weak stream ☐ Straining
☐ Testicle Pain ☐ Pain in side: R / L ☐ Urinating at night (# _____)

In compliance with California OHSA Title 8, Section 5199, healthcare facilities must prescreen patients for aerosol transmissible diseases. Please let the nurse know if you have any of the following:

Yes No History or Symptoms of Tuberculosis *(productive cough, bloody sputum, fever, malaise, night sweats, unexplained weight loss)*

Yes No Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis