ACADEMIC 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 AU.

My Main Problem(s) is/are:

☐ Enlarged Prostate ☐ Blood in urine ☐ High PSA ☐ Bladder Infection
☐ Kidney Stones ☐ Prostate Infection ☐ Urinary Incontinence ☐ Bladder Cancer
☐ Prostate Cancer ☐ Erectile Dysfunction ☐ Overactive Bladder ☐ Infertility
☐ Lump in Testicle ☐ 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
☐ Thyroid Condition ☐ Diabetes
☐ Anemia ☐ Enlarged lymph nodes ☐ Easy bleeding/bruising ☐ Transfusion History
☐ Immune Deficiency
☐ Asthma ☐ “Hay Fever”
☐ Arthritis ☐ Chronic Back Pain ☐ Chronic Neck Pain
☐ Blood in Urine ☐ Urinary tract infection ☐ Kidney Stones ☐ Urine leakage

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: ______________________________

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____

Surgical History:

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

Please list your other operations: ______________________________

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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:

Prostate Cancer ☐ No ☐ Yes, whom? ____________
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? ____________

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

Patient's Signature: ____________