Amarillo Urology Associates, LLP

PATIENT DEMOGRAPHIC INFORMATION

NAME _____ **SSN:** _____
LAST FIRST MI

DOB _____ **AGE** ____ **MALE** ☐ **FEMALE** ☐ **MARITAL STATUS:** MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ PARTNER ☐

ADDRESS: _____
STREET CITY, STATE ZIP

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

EMAIL ADDRESS: _____ **PREFERRED CONTACT METHOD:** HOME PHONE ☐ CELL PHONE ☐ TEXT ☐ WORK PHONE ☐ EMAIL ☐

EMERGENCY CONTACT _____
NAME PHONE NBR RELATION

ETHNICITY _____ **PREFERRED LANGUAGE** _____

EMPLOYER _____ **OCCUPATION** _____

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

CARE TEAM:

CARDIOLOGIST _____ NEPHROLOGIST _____

OBGYN _____ ONCOLOGIST _____

PULMONOLOGIST _____ ENDOCRINOLOGIST _____

DRUG ALLERGIES:

DRUG NAME	TYPE OF REACTION

CURRENT MEDICATIONS: (if you have an updated list, please provide to the staff for a copy)

DRUG NAME	DOSAGE	REASON TAKING	WHO PRESCRIBED?

If more room is needed, please use the back.

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GYNECOLOGICAL HISTORY ** FEMALES ONLY **

TOTAL/PARTIAL HYSTERECTOMY ☐ TUBAL LIGATION ☐ MENOPAUSE ☐

CURRENT BIRTH CONTROL METHOD _____

FAMILY HISTORY: **MEDICAL ISSUES:**

FATHER: LIVING? YES ☐ CURRENT AGE ____ CANCER YES ☐ NO ☐ ORGAN _____
NO ☐ AGE DECEASED ____ OTHER _____

MOTHER: LIVING? YES ☐ CURRENT AGE ____ CANCER YES ☐ NO ☐ ORGAN _____
NO ☐ AGE DECEASED ____ OTHER _____

OF BROTHERS: ____ AGES OF THOSE LIVING ____ ____ ____ ____ AGES AT TIME OF DEATH ____ ____ ____ ____

MEDICAL ISSUES: _____

OF SISTERS: ____ AGES OF THOSE LIVING ____ ____ ____ ____ AGES AT TIME OF DEATH ____ ____ ____ ____

MEDICAL ISSUES: _____

SOCIAL HISTORY:

SUBSTANCE USE:

DO YOU OR HAVE YOU EVER SMOKED TOBACCO? NEVER SMOKER ☐ FORMER SMOKER ☐

CURRENT EVERYDAY SMOKER ☐ CURRENT SOME DAYS SMOKER ☐ CURRENT SMOKER STATUS UNKNOWN ☐

HOW MANY YEARS HAVE YOU SMOKED TOBACCO? _____ AT WHAT AGE DID YOU START? _____

WHAT IS YOUR CURRENT PACK YEARS? < OR EQUAL TO 10 PACK YEARS ☐ 10-19 PACK YEARS ☐

20-29 PACK YEARS ☐ 30+ PACK YEARS ☐

HOW MUCH TOBACCO DO YOU SMOKE? NONE ☐ 1 PACK/WEEK ☐ 2 PACKS/WEEK ☐

¼ PACK/DAY ☐ ½ PACK/DAY ☐ 1 PACK/DAY ☐ 2 PACKS/DAY ☐ 3 OR MORE PACKS/DAY ☐

DO YOU OR HAVE YOU EVER USED ANY OTHER FORMS OF TOBACCO OR NICOTINE? YES ☐ NO ☐

DO YOU OR HAVE YOU EVER USED E-CIGARETTES OR VAPE? NEVER ☐ FORMER USER ☐ CURRENT USER ☐

DO YOU OR HAVE YOU EVER USED SMOKELESS TOBACCO? NEVER ☐ FORMER USER ☐

CURRENT SNUFF USER ☐ CURRENTLY CHEWS TOBACCO ☐ CURRENTLY USES MOIST POWDER TOBACCO ☐

HOW MANY YEARS HAVE YOU USED? _____ HAS TOBACCO CESSATION COUNSELING BEEN PROVIDED? YES ☐ NO ☐

WHAT IS YOUR LEVEL OF ALCOHOL CONSUMPTION? NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY ☐

HOW MANY DAYS IN THE PAST YEAR HAVE YOU CONSUMED 5 OR MORE DRINKS? _____

HAVE YOU EVERY BEEN COUNSELED FOR UNHEALTHY ALCOHOL USE? YES ☐ NO ☐

DO YOU USE ANY ILLICIT OR RECREATIONAL DRUGS? YES ☐ NO ☐ IF YES, WHICH DRUGS? _____

HAVE YOU USED IV DRUGS? YES ☐ NO ☐

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WHAT IS YOUR LEVEL OF CAFFEINE CONSUMPTION? NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY ☐

EDUCATION & OCCUPATION: circle grade/level of school

WHAT IS THE HIGHEST GRADE/LEVEL OF SCHOOL YOU HAVE COMPLETED OR THE HIGHEST DEGREE YOU HAVE RECEIVED?

NEVER ATTENDED/KINDERGARTEN ONLY *1ST* *2ND* *3RD* *4TH* *5TH* *6TH* *7TH*

8TH *9TH* *10TH* *11TH* *12TH-NO DIPLOMA* *GED OR EQUIVALENT* *HIGH SCHOOL GRADUATE*

SOME COLLEGE-NO DEGREE *ASSOC. DEGREE-OCCUPATIONAL/TECHNICAL/VOCATIONAL* *ASSOC. DEGREE-ACADEMIC*

BACHELOR'S DEGREE *MASTER'S DEGREE* *PROFESSIONAL SCHOOL DEGREE (MD, DO)* *DOCTORAL DEGREE (PhD)*

ARE YOU CURRENTLY EMPLOYED? YES ☐ NO ☐ IF YES, WHERE? _____

OCCUPATION? _____

ACTIVITIES OF DAILY LIVING:

ARE YOU BLIND OR DO YOU HAVE DIFFICULTY SEEING? YES ☐ NO ☐

ARE YOU DEAF OR DO YOU HAVE DIFFICULTY HEARING? YES ☐ NO ☐

ARE YOU ABLE TO WALK? circle answer YES: W/O RESTRICTIONS YES: W/ASSISTIVE DEVICES

YES: LIMITED SELF MOBILITY; GENERALLY WHEELED MOBILITY NO: CONFINED TO CHAIR NO: INDEPENDENT IN WHEELCHAIR

NO: REQS MINIMAL HELP IN WHEELCHAIR NO: DEPENDENT ON HELPER PUSHING WHEELCHAIR

NO: UNABLE TO WALK NO: UNABLE TO INITIATE WALKING NO: BED-RIDDEN

ADVANCE DIRECTIVE:

DO YOU HAVE AN ADVANCE DIRECTIVE? YES ☐ NO ☐

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? YES ☐ NO ☐

RELATIONSHIP STATUS: circle answer

MARRIED SINGLE DIVORCED SEPARATED WIDOWED PARTNER

OTHER UNKNOWN

SURGICAL PROCEDURES: List all past surgical procedures and the year they were performed

PATIENTS AGE 50 & OVER: HAVE YOU HAD A COLONOSCOPY? YES ☐ NO ☐ WHEN: _____

PROCEDURE	YEAR PERFORMED	PROCEDURE	YEAR

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PAST MEDICAL HISTORY:

CONDITION	YES	NO	CONDITION	YES	NO
BLEEDING DISORDER			HEART DISEASE		
CANCER			HIGH BLOOD PRESSURE		
DIABETES			HIGH CHOLESTROL		
DIVERTICULITIS			KIDNEY STONES		
EMPHYSEMA			MENTAL HEALTH DISORDER		
ENLARGED PROSTATE			SEIZURES		
HIV/HEPATITIS			STROKE		
OTHER:					

Please mark any symptoms that you are currently experiencing today.

CONSTITUTIONAL: ☐ FEVER ☐ NIGHT SWEATS ☐ WEIGHT GAIN _____lbs ☐ WEIGHT LOSS _____lbs
☐ EXERCISE INTOLERANCE ☐ SEDATION ☐ LETHARGY ☐ CHILLS ☐ MALAISE

CARDIOVASCULAR: ☐ CHEST PAIN ON EXERTION ☐ ARM PAIN ON EXERTION ☐ SHORTNESS OF BREATH WHILE WALKING
☐ SHORTNESS OF BREATH WHEN LYING DOWN ☐ PALPITATIONS ☐ KNOWN HEART MURMUR
☐ LIGHT-HEADED ON STANDING ☐ ANKLE SWELLING

RESPIRATORY: ☐ COUGH ☐ WHEEZING ☐ SHORTNESS OF BREATH ☐COUGHING UP BLOOD ☐ SLEEP APNEA

GASTROINTESTINAL: ☐ ABDOMINAL PAIN ☐ NAUSEA ☐ VOMITTING ☐ CONSTIPATION ☐ CHANGE IN APPETITE
☐ BLACK OR TARRY STOOLS ☐ FREQUENT DIARRHEA ☐ VOMITING BLOOD ☐ DYSPEPSIA ☐ GERD

GENITOURINARY: ☐ URINARY LOSS OF CONTROL ☐ DIFFICULTY URINATING ☐ INCREASED URINARY FREQUENCY
☐ HEMTURIA ☐ INCOMPLETE EMPTYING

MUSCULOSKELETAL: ☐MUSCLE ACHES ☐MUSCLE WEAKNESS ☐ARTHRALGIAS/JOINT PAIN ☐BACK PAIN ☐CRAMPS
☐ SWELLING IN THE EXTREMITIES ☐ NECK PAIN ☐ DIFFICULTY WALKING ☐ OSTEOPOROSIS ☐ FRACTURES

SKIN: ☐ ABNORMAL MOLE ☐ JAUNDICE ☐ RASH ☐ ITCHING ☐ DRY SKIN ☐ GROWTHS/LESIONS ☐ LACERATIONS
☐ NON-HEALING AREAS ☐ CHANGES IN HAIR/NAILS ☐ PSORIASIS ☐ CHANGE IN SKIN COLOR ☐ BREAST LUMP

NEUROLOGIC: ☐LOSS OF CONSCIOUSNESS ☐WEAKNESS ☐NUMBNESS ☐SEIZURES ☐DIZZINESS ☐ PARALYSIS
☐ FREQUENT OR SEVERE HEADACHES ☐ MIGRAINES ☐ RESTLESS LEGS ☐ TREMOR ☐ GAIT DYSFUNCTION

PSYCH: ☐ DEPRESSION ☐ SLEEP DISTURBANCES ☐FEELING UNSAFE IN RELATIONSHIP ☐RESTLESS SLEEP
☐ ALCOHOL ABUSE ☐ ANXIETY ☐ HALLUCINATIONS ☐ MOOD SWINGS ☐ MEMORY LOSS
☐ AGITATION ☐ DEMENTIA ☐ DELIRIUM

ENDOCRINE: ☐ FATIGUE ☐ INCREASED THIRST ☐ HAIR LOSS ☐ INCREASED HAIR GROWTH ☐ COLD INTOLOERANCE

HEMATOLOGIC/LYMPHATIC: ☐ SWOLLEN GLANDS ☐ EASY BRUISING ☐ EXCESSIVE BLEEDING ☐ ANEMIA ☐ PHLEBITIS