NORTH ATLANTA UROLOGY ASSOCIATES PC

Howard C. Goldberg; M.D. Douglas A. Nyhoff; M.D. Paul L. Rubin; M.D. Jin S. Yeoh M.D.

PATIENT INFORMATION SHEET

First Name: _____ Last Name: _____ Date: _____
Mailing Address: _____
City: _____ State: ____ Zip:_____
Home Number: _____
Cell Number:_____
Work Number: _____
Fax Number: _____

Sex: Male / Female (circle one) Age:_____ Date of Birth:_____Marital Status: _____
Race:_____Ethnicity: _____ Primary Language: _____
Social Security Number: _____-____-_____ Email: _____
Emergency Contact Name: _____
Phone Number: _____

Preferred Pharmacy Name: _____Address: _____
City:_____State:___ Zip: _____Phone Number: _____
Referring / Primary Care Physician: _____
Phone Number:_____

Are you a resident of a Nursing Home facility? (Yes / No) If answered yes, What is the Facility Name & Address:_____ City: _____
State: _____ Zip:_____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID#: _____
Policy Holder: _____DOB:_____

Secondary Insurance: _____ Member ID#: _____
Policy Holder: _____ DOB: _____

Patient / Guardian Signature:_____ Date: _____

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PATIENT HISTORY

Please answer all questions to your fullest ability, if there is no answer, please write N/A. If you have medications, please list them or provide your own list.

First Name: _____ Last Name: _____ DOB: _____

Reason for visit today:_____

Surgical History with dates:

_____

_____

_____

List all medical conditions that you have and had:

_____

_____

_____

List all your current medications you are taking:

_____

_____

_____

List all your drug allergies:

_____

_____

_____

FAMILY HISTORY

Do any of your immediate family members have or havemhad the following conditions? If yes. Please explain who has or had the illness.

Bladder Cancer_____ Prostate Cancer_____

Kidney Cancer_____ Testicular Cancer_____

Other Medical Illnesses and Conditions:

_____

SOCIAL HISTORY

Do you smoke? (Y / N) If yes, how many do you smoke per day? _____ When did you start smoking?

_____

Do you drink alcohol? (Y / N) If yes, how many drinks per day?_____

Do you drink caffeinated drinks? (Y / N) If yes, How many drinks per day?_____

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REVIEW OF SYSTEMS

Please circle or check the problems in each body system.

CONSTITUTIONAL: ___fever ___chills___weight loss

EARS, NOSE, THROAT: ___ hearing loss ___nasal stuffiness ___ sore throat

RESPIRATORY: ___ shortness of breath ___ wheezing ___coughing

CARDIOVASCULAR: ___chest pain ___ swollen ankles ___ irregular heartbeat

HEME/LYMPH: ___ swollen glands ___ abnormal bleeding ____ transfusion history

GASTROINTESTINAL: ___ abdominal pain ___change in bowels ___ nausea/vomiting

GENITOURINARY: ____incontinence ___ painful urination ___ blood in urine

MUSCULOSKELETAL: ___ chronic back pain ___chronic neck pain ___sore muscles

NEUROLOGICAL: ___ tingling ___ dizziness ___ numbness

INTEGUMENTARY/SKIN: ___ rash___ persistent itching ___history of skin cancer

PSCHOLOGICAL: ___depression ___ difficulty sleeping ___ suicidal thoughts