Northeast Georgia Physicians Group- Urology

DATE:_____ NAME:_____ AGE:_____

Weight:_____ Height:_____ BP:____/____ Pulse:_____ Resp:_____ O2:_____ Temp:_____

What problem are we seeing you for? _____

On a pain scale of (**0 to 10**), at what number would you rate your pain? _____

How long have you had this problem? _____

Who referred you?_____ Primary Care Physician: _____

PAST MEDICAL HISTORY: Have you ever been diagnosed with any of these conditions?

☐ Headaches:	☐ Syncope	☐ Congestive Heart Failure	☐ Anemia
☐ Implanted Devices	☐ High Blood Pressure	☐ Stomach Ulcers	☐ Epilepsy
☐ Stroke	☐ Low Blood Pressure	☐ Diabetes	☐ Arthritis
☐ TIA	☐ High Cholesterol	☐ Low Blood Sugar	☐ Fibromyalgia
☐ Carotid Artery Disease	☐ Thyroid Disease	☐ Liver Disease	☐ Psychiatric Disorder
☐ Coronary Artery Disease	☐ Asthma	☐ Hepatitis	☐ Anxiety
☐ Heart Attack	☐ Emphysema	☐ Kidney Stones	☐ Depression
☐ Abnormal Heart Rhythm	☐ COPD	☐ Kidney Disease	☐ Claustrophobia

Other:_____

Have you ever had cancer? ☐ Yes ☐ No Where?

PAST SURGICAL HISTORY: Have you ever had any of the following surgeries?

☐ Back Surgery	☐ Pacemaker
☐ Neck Surgery	☐ Cardiac Stent
☐ Carpal Tunnel Repair	☐ Hysterectomy
☐ Carotid Surgery	☐ Appendectomy
☐ Brain Surgery	☐ Gallbladder

Other:_____

SOCIAL HISTORY:

Alcohol Use: ☐ Yes ☐ No How Often? _____ Caffeine Beverages per Day? _____

Tobacco Products: ☐ Yes ☐ No Packs per day? Under Stress? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No Occupation? ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Disability? ☐ Yes ☐ No ☐ Pending ☐ Seeking

FAMILY HISTORY: Do any of your blood relatives have or have they ever had any of these conditions? Please list who.

☐ Heart Disease	_____	☐ Kidney Disease	_____	☐ Psychiatric History	_____
☐ Hypertension		☐ Neuropathy		☐ Drug Abuse	
☐ Stroke		☐ Seizure Disorder		☐ Parkinson's	
☐ Back Surgery	_____	☐ Diabetes	_____	☐ Arthritis	_____
☐ Headaches	_____	☐ Brain Aneurysm	_____	☐ Trembling	_____
☐ Cancer	_____				

REVIEW OF SYSTEMS (Check Current or Present Symptoms):

GENERAL:

☐ Weight Loss ☐ Weight Gain ☐ Fatigue ☐ Weakness
☐ Fever ☐ Chills

SKIN:

☐ Rashes ☐ Lesions ☐ Lumps ☐ Slow Healing Wounds

EYES:

☐ Pain ☐ Double Vision ☐ Blurry Vision ☐ Loss of Vision

EARS, NOSE & THROAT:

☐ Hearing Loss ☐ Ringing in Ears ☐ Vertigo ☐ Nose Bleed
☐ Sore Throat

RESPIRATORY:

☐ Cough ☐ Wheezing ☐ Shortness of Breath ☐ Painful Breathing

CARDIOVASCULAR:

☐ Chest Pain or Discomfort ☐ Swelling ☐ Shortness of Breath with Activity ☐ Tightness

GASTROINTESTINAL:

☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea

VASCULAR:

☐ Leg Cramping ☐ Leg Swelling ☐ Calf Pain when Walking

MUSCULOSKELETAL:

☐ Muscle or Joint Pain ☐ Muscle Weakness ☐ Stiffness

NEUROLOGIC:

☐ Weakness ☐ Numbness ☐ Tingling ☐ Tremor
☐ Memory Loss ☐ Difficulty Walking ☐ Headache ☐ Off-Balance
☐ Dizziness

PSYCHIATRIC

☐ Loss of Concentration ☐ Anxiety ☐ Irritability ☐Depression

HEMATOLOGIC:

☐ Ease of Bleeding ☐ Ease of Bruising

URINARY:

☐ Frequency ☐ Painful Urination

Allergies? ☐ Yes ☐ No If yes, please list allergies and reactions: _____

_____

Northeast Georgia Physicians Group

MEDICATION LIST

NAME:_____ **DOB:**_____

PHARMACY:_____ **PHONE:**_____

MAIL-IN PHARMACY:_____

PLEASE PROVIDE US WITH COMPLETE LIST OF MEDICATIONS BELOW, INCLUDING DOSE AND HOW MANY TIMES PER DAY YOU TAKE EACH MEDICATION.

MEDICATION	DOSE	TIMES PER DAY