Urology Associates of SENC, P.A.

Patient Information

Patient Name:	Last:		First:		Middle:
Patient Address:	Street:				Apt/Bldg/Lot:
City:		State:		Zip:	
Email Address:					
Phone:	Cell:		Home:		Other:
Sex:	☐ Male	☐ Female	Date of Birth:		SSN:
Marital Status:	☐ Single	☐ Widowed	Race:		Pref. Language:
	☐ Married	☐ Divorced	Ethnicity:		

Employer:		Phone:	
Please List Two: Emergency Contact:		Phone:	
Emergency Contact:		Phone:	
Guarantor must be listed if the patient is under 18 years of age. The guarantor must be the person who signs the consent for the patient to receive treatment today.			
Guarantor Name:		Relationship to Patient:	
Guarantor Address:			
Guarantor Phone:		Guarantor SSN:	

Please present your insurance card/cards to the front desk. If either insurance is not in the patient's name, we can not file charges without the following information.					
Insured Name:		Insured DOB:		Insured SSN:	
Primary Insurance:		Policy #:		Group #:	
Secondary Insurance:		Policy #:		Group #:	

Referring Doctor:		Phone #:	
Primary Care Doctor:		Phone #:	

Patient DOB:		Today's Date:	
Patient Name: (Please Print)			

Allergies: Please indicate all allergies and list any not named:			Other:		
☐ None	☐ IV Contrast	☐ Iodine	☐ Aspirin	☐ Codeine	☐ Demerol
☐ Penicillin	☐ Sulfa	☐ Cipro	☐ Macrobid	☐ Latex	☐ Morphine

Medical History: Past Medical Illnesses. Please list any not named:			*Other:*			
☐ Acid Reflux	☐ Breast Cancer	☐ Glaucoma	☐ HIV/Aids	☐ Kidney Stones	☐ Rheumatic Fever	☐ Stroke
☐ Anemia	☐ Colon Cancer	☐ Gout	☐ Hypertension	☐ Low Testosterone	☐ Seizures	☐ TB (Tuberculosis)
☐ Asthma	☐ Colon Polyps	☐ Heart Attack	☐ Irregular Heartbeat	☐ Migraines	☐ Sexually Transmitted Disease	☐ Thyroid Disease
☐ Atrial Fibrillation	☐ Depression	☐ Heart Failure	☐ Irritable Bowel	☐ Prostate Cancer	☐ Sleep Apnea	☐ Urinary Incontinence
☐ Back Pain	☐ Diabetes	☐ Hiatal Hernia	☐ Kidney Cancer	☐ Prostate Infections	☐ Skin Cancer	☐ None
☐ BPH	☐ Emphysema	☐ High Cholesterol	☐ Kidney Failure	☐ Recurrent UTIs	☐ Stomach Ulcers	

Surgical History: Please list all surgeries, including the year	

Social History:	Tobacco Use:	☐ Current User	☐ Former User	If yes, year quit:	☐ Never Used
Type:		Amount per day:		# of years used:	

Alcohol Use:	☐ Current User	☐ Former User	☐ Never Used	If current, Type:
				How much per day/week:

Drug Use/Substance Abuse:	☐ Current User	☐ Former User	☐ Never Used	If current, please list:

Family History:	☐ Prostate Cancer	☐ Kidney Cancer	☐ Bladder Cancer	☐ Kidney Stones	☐ No history of urinary cancers	Other:

Health Maintenance: Please provide the most recent dates.	Colonoscopy Date:	Flu Vaccine Date:	Pneumonia Vaccine Date:	Covid Vaccine(s) Date:

Medication List:	Mail Order Pharmacy:
Local Pharmacy Name and Location:	

Please indicate medication name, strength, and times per day (i.e. Aspirin, 81mg, Once Daily). If you need more space please write on other side of page:	

Patient DOB:		Today's Date:	
Patient Name: (Please Print)			

Review of Systems					
Please Check Yes or No					
General:	Yes	No	Cardiovascular:	Yes	No
Weight Gain			Chest Pain		
Weight Loss			Edema		
Weight Loss > 10 lbs			Palpitations		
Appetite Loss			Swelling of Legs		
Chills			Gastrointestinal:		
Fever			Hemorrhoids		
Skin:			Abdominal Pain		
Dryness			Change in Bowel Habits		
Hives			Indigestion		
Itching			Nausea		
Rash			Vomiting		
HEENT:			Genitourinary:		
Blurred Vision			Change in Urinary Stream		
Headache			Burning during Urination		
Eye Pain			Frequency		
Vision Loss			Blood in Urine		
Hearing Loss			Incontinence		
Ear Pain			Urgency		
Nose Bleed			Impotence (Men)		
Sinus Pain			Nighttime Urinating		
Sore Throat			Kidney Pain		
Change in Voice			Musculoskeletal:		
Respiratory:			Bone Pain		
Cough			Neurological:		
Decreased Exercise Tolerance			Trouble Walking		
Trouble Breathing			Headaches		
Wheezing			Seizures		
Shortness of Breath			Psychiatric:		
Breast:			Anxiety		
Breast Mass			Depression		
Breast Pain			Endocrine:		
Breast Swelling			Sexual Dysfunction		
Nipple Discharge			Hematology:		
Skin Changes			Easy Bruising		