BAY AREA UROLOGY
A Service of MUNSON MEDICAL CENTER

3922 Cedar Run Road
Traverse City, MI 49684
(231)935-0322

New Patient Intake form

Please fill out this questionnaire as thoroughly as possible. All information contained in these pages is completely confidential.

Personal Information

Today's Date_____ Primary care physician _____

Who referred you to our office? _____

Name_____ Age _____ Date of Birth_____

Address_____ Apt #_____ SS# _____

City_____ State_____ Zip Code_____

Primary phone #_____ Secondary phone # _____

What is the best way to contact you? □ Primary # □ Secondary #
Is it OK to leave messages on your primary phone? □ YES □ NO
Is it OK to leave test results on your primary phone? □YES □NO
Marital Status □ Married □ Single □ Divorced □ Widowed

Medical insurance company _____ Policy # _____
Subscriber Name _____ Subscriber Date of Birth _____

Prescription insurance coverage if different than above _____
Policy # _____

Your local Pharmacy _____
Mail order Pharmacy _____

Have you ever been a patient with any of our doctors in the past? □ YES □ NO
If yes, which doctor, when and the reason for the visit. _____
Patient's employer name and address_____
If the patient is a Minor; Responsible party's name _____

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Date:_____ Last Name: _____ First Name: _____

DOB: _____ Height: _____ Weight: _____ Occupation: _____

What is the main reason for your visit today? _____

MEDICATIONS-If you have an updated list of medications with you we would be happy to copy it. Please provide to the staff. Please list all Prescriptions, Non-Prescription and Over-the-counter medications!

Name of medication	**Dosage**	**How Often**

Do you take any blood Thinners? Yes No , if yes what kind?_____

Medication Allergies and Reactions: **NO KNOWN ALLERGIES** □

Latex Allergy □ Iodine Allergy □ Environmental Allergy □

YOUR Health History, Please check any that apply to you.

- □ Allergies
- □ Anemia
- □ Angina
- □ Arthritis
- □ Asthma
- □ Benign prostatic hypertrophy
- □ Bleeding disorder
- □ Cancer(type)_____
- □ Congestive heart failure
- □ COPD
- □ Coronary Artery disease
- □ Depression
- □ Diabetes
- □ Diverticular disease
- □ Elevated Lipids/High Cholesterol
- □ GERD
- □ Gout
- □ Headache, Migraine
- □ Hepatitis/liver disease
- □ High Blood pressure
- □ Inflammatory bowel disease
- □ Heart Attack
- □ Osteoporosis
- □ Peptic Ulcer disease
- □ Renal disease
- □ Seizure disorder
- □ Stroke
- □ Thyroid disease
- □ Urinary infection (chronic)
- □ Urolithiasis
- □ Incontinence of Urine
- □ Atrial Fibrillation
- □ High Cholesterol
- □ Prostate Enlargement
- □ Prostatitis(inflammation)
- □ Erectile Dysfunction
- □ Interstitial Cystitis
- □ Kidney Stones
- □ Leukemia
- □ Lymphoma Multiple Myeloma
- □ AIDS
- □ Peripheral Vascular Disease
- □ Dementia
- □ Connective Tissue Disease
- □ Hemiplegia or Paraplegia
- □ Dialysis/Kidney transplant
- □ Pregnancies #_____ Live births # _____
- □ Delivery Type _____

Have you had your **FLU** shot this year? □YES □NO, Date_____

Have you ever had a **PNEUMONIA** vaccine? □YES □NO, Date_____

Do you drink Alcohol? □ **YES** □ **NO**
Type_____ Amount daily _____
Do you drink caffeine? □ **YES** □ **NO**
Type _____ Amount daily _____
Do you use tobacco products? □ **NEVER** □ **YES** □ **FORMER**
□ CIGARETTES □ CHEWING □ CIGAR □ PIPE
If yes, how much per day? _____ **How may years?** _____
if you quit, what year?_____
Do you use recreational drugs? □ **YES** □ **NO**

YOUR Surgical History: **Please check all that apply.**

- □ Adrenalectomy
- □ Angioplasty
- □ Appendectomy
- □ Back Surgery
- □ Bladder Augmentation
- □ Blood Transfusion
- □ CABG
- □ Cardiac Pacemaker
- □ Cholecystectomy/Gall Bladder Removal
- □ Cystectomy
- □ Cystoscopy
- □ Dialysis
- □ Green light PVP
- □ Herniorrhaphy
- □ Hysterectomy
- □ Hydrocelectomy
- □ Lithotripsy
- □ Nephrectomy
- □ Penile implant, Inflatable
- □ Penile implant, Non-inflatable
- □ Percutaneous nephrolithoty
- □ Prostate Biopsy
- □ TURP
- □ Ureteroscopy
- □ Ureteroscopy, Calculi extraction
- □ Ureteroscopy, stent insertion
- □ Vasectomy
- □ Coronary/Cardiac Stent
- □ Gastric Bypass
- □ Hip replacement
- □ Knee replacement
- □ Joint replacement
- □ Circumcision
- □ Other _____

YOUR Family Medical History
Please Specify which family member this applies to (Mother, Father, Siblings, etc)

- □ ADD/ADHD _____
- □ Alcoholism _____
- □ Allergies _____
- □ Alzheimer's disease _____
- □ Asthma_____
- □ Benign Prostatic hypertrophy _____
- □ Blood Disease _____ _____
- □ Bladder Cancer _____
- □ Prostate Cancer _____
- □ Cardiovascular disease_____
- □ Coronary artery disease_____
- □ Developmental delay _____
- □ Diabetes _____
- □ Eczema _____
- □ Elevated Lipids _____
- □ Genetic disease _____
- □ Gout _____
- □ Hearing impairment _____
- □ High Blood Pressure _____
- □ Irritable bowel disease _____
- □ Learning disability _____
- □ Renal Cancer _____
- □ Mental illness _____
- □ Migraines_____
- □ Renal Disease _____
- □ Renal Failure _____
- □ Seizure disorder _____
- □ Stroke _____
- □ Thyroid disorder _____
- □ Testicular Cancer _____
- □ Urinary tract infections _____
- □ Urolithiasis _____
- □ Atrial Fibrillation _____
- □ Congestive Heart Failure _____
- □ COPD _____
- □ Heart Attack _____
- □ High Cholesterol _____
- □ Osteoarthritis _____
- □ Prostate Enlargement _____
- □ Incontinence of Urine _____
- □ Kidney Disease _____
- □ Kidney Stones _____
- □ Other _____

REVIEW OF SYSTEMS

Do you now, or in the past 10 days have any problems related to the following systems? **PLEASE CHECK NEGATIVE OR POSITIVE TO EACH QUESTION.** If you answered POSITIVE to any of the following, It is highly suggested that you inform your family physician and/or specialist to address these symptoms.

CONSTITUTIONAL

Neg	Pos	
○	○	Chills
○	○	Fever
○	○	Weight loss

Other _____

HEENT

Neg	Pos	
○	○	Blurred vision
○	○	Double vision
○	○	Ear infection
○	○	Eye pain
○	○	Hearing loss
○	○	Sinus infection
○	○	Sore throat

Other _____

RESPIRATORY

Neg	Pos	
○	○	Chronic Cough
○	○	Dyspnea
○	○	Known TB exposure
○	○	Wheezing

Other _____

CARDIOVASCULAR

Neg	Pos	
○	○	Chest pain
○	○	Heart murmur
○	○	Palpitations
○	○	Varicose veins

Other _____

GASTROINTESTINAL

Neg	Pos	
○	○	Abdominal pain
○	○	Blood in stool
○	○	Constipation
○	○	Diarrhea
○	○	Heartburn
○	○	Loss of appetite
○	○	Nausea
○	○	Vomiting

Other _____

GENITOURINARY

Neg	Pos	
○	○	Dysuria
○	○	Erectile dysfunction
○	○	Blood in urine
○	○	Urinary frequency
○	○	Urinary incontinence
○	○	Urinary retention

Other _____

REPRODUCTIVE

Neg	Pos	
○	○	Penile discharge
○	○	Sexual dysfunction

Other _____

METABOLIC/ENDOCRINE

Neg	Pos	
○	○	Cold intolerance
○	○	Excessive thirst
○	○	Fatigue
○	○	Gynecomastia
○	○	Heat intolerance
○	○	Hot flashes

Other _____

NEUROLOGICAL

Neg	Pos	
○	○	Difficulty walking
○	○	Headache
○	○	Memory loss
○	○	Seizures
○	○	Tremors

Other _____

PSYCHIATRIC

Neg	Pos	
○	○	Anxiety
○	○	Depression
○	○	Insomnia

Other _____

INTEGUMENTARY

Neg	Pos	
○	○	Contact allergy
○	○	Hives
○	○	Itching skin
○	○	Rash

Other _____

MUSCULOSKELETAL

Neg	Pos	
○	○	Arthritis
○	○	Back pain
○	○	Joint pain
○	○	Neck pain

Other _____

HEMATOLOGIC/LYMPHATIC

Neg	Pos	
○	○	Easy Bleeding
○	○	Lyphadenopathy
○	○	Petechiae

Other _____

IMMUNOLOGIC

Neg	Pos	
○	○	Asthma
○	○	Food Allergies

Other _____