CHRISTUS ST. VINCENT
Urology Associates

Patient Registration Form

Name: _____ DOB: _____
Current Height: _____ Current Weight: _____

Family History -- Please indicate what family members have or have had any of the following:

Arthritis: _____ Heart Attack: _____
Bladder Cancer: _____ Kidney Cancer: _____
Prostate Cancer: _____ Cancer (specify): _____
Diabetes: _____ Smoke: _____
Other (please specify: _____ Not Applicable: _____

Review of Systems -- Please CIRCLE all in each category that currently apply to you.

Constitutional
Chills
Sleep Apnea
Weight Gain
Weight Loss

Eyes
Blind
Glaucoma

Allergies
Drug allergies
Food Allergies
Environmental
Seasonal

Neurological
Dizzy Spells
Numbness
Stroke
Tremors

Endocrine
Excessive Thirst
Tired/Sluggish
Too hot/too cold

Gastrointestinal
Abdominal Pain
Heartburn
Nausea
Tarry Stool

Cardiovascular
Chest Pain
Irregular Heartbeat
Swelling in Ankles
High Blood Pressure

Integumentary
Changing Moles
Persistent Itch
Skin Rash

Musculoskeletal
Joint Pain
Back Pain
Muscle Cramps

Ear/Nose/Throat
Ear Infection
Sinus Problems
Sore Throat

Genitourinary
Blood in Urine
Burning Sensation
Blood in Semen
Weak Stream
Leaking Urine

Respiratory
Frequent Cough
Shortness of Breath
Wheezing

Hematologic
Swollen Glands
Blood Clots
Hepatitis
HIV/AIDS

Psychological
Anxiety
Depression

How many times do you urinate at night? _____

Past Medical History – Please circle if you have had any of the following diseases or conditions.

Cardiovascular
Anemia
Arrhythmia
Heart Attack
Heart Murmur
Hemophilia
Rheumatic Fever
Stroke
Hypertension

Endocrine
Diabetes – insulin
Diabetes – no insulin
Hyperthyroidism
Hypothyroidism

GI
Hemorrhoids
Hiatal Hernia
Liver Disease

GU
Kidney Cancer
Kidney Stones
Prostate Cancer
UTI
Venereal Disease

HEENT
Cataracts
Deviated Septum
Glaucoma

Neurological
Alcoholism
Alzheimer's
Eating Disorder
Epilepsy
Seizures

Respiratory
Asthma
Bronchitis
Lung Disease
Tuberculosis

Cancer
Brain
Breast
Cervical
Colon
Gastric
Lung
Melanoma
Ovarian
Pancreatic
Rectal
Testicular
Bladder
Uterine

FORM CONTINUES →

Name: _____ Appointment Date: _____

Date of Birth: _____ Date Form Completed: _____

Referring Doctor: _____ Primary Care Physician: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

Social History

Marital Status: _____Single _____Married _____Divorced _____Widowed _____Life Partner

How many children do you have?_____

Alcohol Consumption: _____None _____Yes _____Occasional/Social Number of drinks per day_____

Do you currently use Tobacco? _____No _____Yes

If yes, Cigarettes per day _____ Packs per day _____ Smokeless Tobacco _____

Previously used tobacco? _____No _____Yes If yes, how many years ago did you quit? _____

Recreation Drugs? _____None If yes, please list: _____

Surgical History

Please list any surgery you have had and year you had that surgery. If none, please note N/A.
