

**WAKE UROLOGICAL ASSOCIATES, P.A / NEW PATIENT QUESTIONNAIRE**

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

**To our patients,**

**A few minutes of your time carefully answering the following questions will help the urologist in assessing your problems and giving you better care. Also, please complete the back of this form.**

1. What is the main reason you are seeing the doctor today? \_\_\_\_\_  
\_\_\_\_\_

2. Have you ever seen a urologist before?    \_\_\_YES            \_\_\_NO

3. PLEASE CHECK IF YOU HAVE A UROLOGIC HISTORY OF:

\_\_\_Kidney disease            \_\_\_Kidney stones            \_\_\_Bladder trouble            \_\_\_Cancer of Urinary Tract  
\_\_\_Cancer of Prostate            \_\_\_Blood in urine            \_\_\_Urine infection            \_\_\_Prostate trouble

4. Have you ever had any problem with or been treated for:

\_\_\_High blood pressure            \_\_\_Heart trouble            \_\_\_Stroke            \_\_\_Tuberculosis  
\_\_\_Stomach Ulcers            \_\_\_Diabetes            \_\_\_Others: \_\_\_\_\_

5. List all of the operations or surgeries you have had:

- 1) \_\_\_\_\_ 2) \_\_\_\_\_
- 3) \_\_\_\_\_ 4) \_\_\_\_\_
- 5) \_\_\_\_\_ 6) \_\_\_\_\_

6. Have any members of your family had: \_\_\_Prostate cancer    \_\_\_Kidney stones    \_\_\_Kidney disease

7. Are you ALLERGIC to any medications? \_\_\_YES \_\_\_NO    Please list below:

- 1) \_\_\_\_\_ 2) \_\_\_\_\_

8. List all the NAMES (and DOSE if known) of the medicine(s) that you take every day including herbs and supplements:

- 1) \_\_\_\_\_dose\_\_\_\_\_ 2) \_\_\_\_\_dose\_\_\_\_\_
- 3) \_\_\_\_\_dose\_\_\_\_\_ 4) \_\_\_\_\_dose\_\_\_\_\_
- 5) \_\_\_\_\_dose\_\_\_\_\_ 6) \_\_\_\_\_dose\_\_\_\_\_

9. Do you take ASPIRIN everyday? \_\_\_YES \_\_\_NO

10. Are you: \_\_\_Single    \_\_\_ Married    \_\_\_Widowed    \_\_\_Separated/Divorced

11. Do you smoke cigarettes? \_\_\_YES \_\_\_NO \_\_\_QUIT (How much? \_\_\_\_\_)

12. Do you drink alcohol? \_\_\_YES \_\_\_NO \_\_\_QUIT (How much? \_\_\_\_\_)

13. Do you drink caffeine? \_\_\_YES \_\_\_NO \_\_\_QUIT (How much? \_\_\_\_\_)

14. What is your occupation? \_\_\_\_\_

**(PLEASE COMPLETE QUESTIONS ON BACK)**

**Wake Urological Associates  
Review of Systems**

**Have you had any problems within the past six months with the following?  
Please circle yes or no**

**General**

Weight Change      Yes    No  
Chills                Yes    No  
Fever                 Yes    No

**Head**

Headache            Yes    No  
Recent Head Injury   Yes    No

**Eyes**

Visual Changes      Yes    No  
Double Vision        Yes    No  
Glaucoma             Yes    No

**Ears/Nose/Mouth/Throat**

Hearing loss         Yes    No  
Recurrent Nose Bleeds   Yes    No

**Respiratory**

Shortness of breath    Yes    No  
Frequent Cough        Yes    No  
Wheezing                Yes    No

**Cardiac**

Chest pain            Yes    No  
Palpitations          Yes    No  
Heart valve disease    Yes    No

**Gastrointestinal**

Abdominal pain        Yes    No  
Frequent Nausea/vomiting   Yes    No  
Frequent diarrhea     Yes    No  
Frequent constipation   Yes    No  
Black stools            Yes    No  
Blood in stools         Yes    No

**Musculoskeletal**

Joint pain             Yes    No  
Joint swelling         Yes    No  
Weakness              Yes    No  
Back pain              Yes    No  
Leg/Ankle swelling    Yes    No

**Neurological**

Dizziness              Yes    No  
Seizures                Yes    No  
Weakness in arms or legs   Yes    No  
Numbness in arms or legs   Yes    No

**Skin**

Chronic rash            Yes    No  
Nonhealing lesions    Yes    No

**Psychiatric**

Nervousness            Yes    No  
Depression             Yes    No  
Mood Changes          Yes    No

**Endocrine**

Thyroid trouble         Yes    No  
Diabetes                Yes    No  
Excessive Thirst        Yes    No

**Hematologic/lymphatic**

Anemia                 Yes    No  
Easy bruising/bleeding   Yes    No  
Swollen lymph nodes    Yes    No

**Allergic/immunologic**

Hay Fever              Yes    No  
Environmental          Yes    No

Patient name: \_\_\_\_\_

Date: \_\_\_\_\_

**Wake Urological Associates, P.A.**

Richard D. Kane, M.D.

Joseph D. Neighbors, Jr., M.D.

Philip M. Newhall, M.D.

Mark W. Jalkut, M.D.

Referred by: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status \_\_\_\_\_ Name of spouse, parent, or significant other \_\_\_\_\_ Relationship \_\_\_\_\_

Employer (Spouse/Parent) \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of person to call in case of emergency \_\_\_\_\_ Phone: \_\_\_\_\_

Name of family Doctor \_\_\_\_\_ Pharmacy \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physicians: \_\_\_\_\_

**Drug Allergies:** 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_

**Artificial Heart Valve:** Y or N **Artificial Joint:** Y or N **Prophylaxis required:** Y or N

Would your religious faith in any way interfere with your medical care? \_\_\_\_\_

Primary Ins. Co. \_\_\_\_\_ Certificate No. \_\_\_\_\_

Claims Address \_\_\_\_\_ Policyholder \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

Secondary Ins. Co. \_\_\_\_\_ Certificate No. \_\_\_\_\_

Claims Address \_\_\_\_\_ Policyholder \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

\* It is the responsibility of the patient to notify this office of pre-admission certification and/or second opinion requirements of their insurance company at the time of scheduling hospital admissions or surgery.

I hereby authorize the release of any medical information pertinent to my care to my referring physician/family physician and insurance companies and accept responsibility for payment of all medical/surgical fees and authorize payment of insurance benefits to WAKE UROLOGICAL ASSOCIATES, P.A., except when the amount due has been paid in full by me.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_