**UNC Urology New Patient Form**

**Primary Care Physician:** ____________________________

If different from above, who is your Referring Physician: ____________

1. **What is the reason for your visit today?**

   __________________________________________________________

2. **What medical conditions or other illnesses do you have?**
   - ________________________  ________________________
   - ________________________  ________________________
   - ________________________  ________________________
   - ________________________  ________________________

3. **What past surgeries have you had?**
   - ________________________  ________________________
   - ________________________  ________________________
   - ________________________  ________________________
   - ________________________  ________________________

4. **If any, what medications do you have allergies to?**
   - ________________________  ________________________
   - ________________________  ________________________
   - ________________________  ________________________
   - ________________________  ________________________

5. **What medications are you currently taking, including aspirin & other non-prescription medication? (Please include dosage frequency)**
   - ________________________  ________________________
   - ________________________  ________________________
   - ________________________  ________________________
   - ________________________  ________________________

Please answer the following questions.

- Do you drink Alcohol?  YES  NO
  If “YES” how many beers/drinks do you average in a week? ____________

- Do you smoke cigarettes?  YES  NO
  If “YES” how many packs per day? ______. How long have you been smoking? ______

- Have you ever smoked?  YES  NO
  If “YES” when did you quit? ____________

- Do you use any other tobacco products?  YES  NO
  If “YES” please specify, ____________
• Have you ever used illegal drugs? YES  NO
  If “YES”, what type of drugs did/do you use? ___________

Please list any medical condition of the family members listed below
  Mother: ________________________________________________
  Father: ________________________________________________
  Brother/Sister: __________________________________________
  Other: __________________________________________________

Please check any symptoms that you experience regularly:
  ___ Weight loss
  ___ Fever / Chills/ Night Sweats
  ___ Fatigue
  ___ Chest Pain or Discomfort
  ___ Swelling in legs
  ___ Cough
  ___ Shortness of breath
  ___ Indigestion
  ___ Nausea
  ___ Constipation
  ___ Abdominal or Stomach Pain
  ___ Arthritis
  ___ Change in Vision
  ___ Headaches
  ___ Numbness or tingling in arms or leg
  ___ Back Pain
  ___ Depression
  ___ Anxiety
  ___ Blood in Urine
  ___ Frequent Urination
  ___ Strong urge to urinate
  ___ Incontinence or leakage
  ___ Weak urinary stream
  ___ Difficulty starting urinary stream
  ___ Wake up at night to more than once
  ___ Burning or pain with urination
  ___ Pain with sexual intercourse
  ___ Discharge from penis or vagina
  ___ Abnormally low sexual desire

Men
  ___ Inability to have or maintain an erection
  ___ Pain in testicles

Women
  ___ Irregular Periods