Today's Date_____

ROSS HOGAN, M.D.

BOARD CERTIFIED • LIMITED LIABILITY COMPANY

GENERAL UROLOGY

NEW PATIENT INTAKE FORM

Patients Name: _____ Date of Birth: _____

Height: _____ Weight: _____

MEDICATION & ALLERGY LIST

ALLERGIES: None Codeine IVP Dye Latex Mycins Penicillin Sulfa Drugs

OTHER ALLERGIES: _____

_____

PHARMACY NAME & ADDRESS: _____

PHARMACY PHONE & FAX NUMBERS: _____

DATE	PLEASE LIST CURRENT MEDICATIONS	DOSAGE	FREQUENCY	NOTES
	(Include over-the-counter drugs, vitamins and herbals.)			

Check any past medical problems:

□ Acid Reflux
□ Anemia
□ Arthritis
□ Asthma
□ Cancer; Type _____
□ Chronic UTIs
□ Congestive Heart Failure
□ COPD
□ Coronary Artery Disease
□ Dementia
□ Depression
□ Diabetes: # of years _____
□ Diverticulitis
□ Enlarged Prostate
□ Glaucoma
□ Gout
□ Heart Attack
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Migraine Headaches
□ Neurologic Disease
_____
□ Osteoarthritis
□ Osteoporosis
□ Peripheral Vascular Dis.
□ Seizure Disorder
□ Stroke
□Thyroid Disease
□ Valvular Heart Disease

Other: _____

Check any past surgical history:

	DATE		DATE		DATE
□ Appendectomy	____	□ Gallbladder Removal	____	□ Knee Replacement	____
□ Back Surgery	____	□ Gastric Bypass	____	□ Laparoscopy	____
□ Heart Bypass	____	□ Hernia Repair	____	□ Pacemaker	____
□ Colon Surgery	____	□ Hip Replacement	____	□ Tonsillectomy	____
□ Heart Stent	____	□ Kidney Removal	____		
□ Cystoscopy	____	□ Kidney Stone Surgery	____		

FEMALE SPECIFIC Check any past surgical history:

□ Bladder Suspension ____
□ Breast Biopsy ____
□ Cesarean Section ____
#___
□ Hysterectomy ____
□ Mastectomy ____
□ Pubovaginal Sling ____
□ Tubal Ligation ____
□ Vaginal Delivery ____
#___
□ Other:
_____

MALE SPECIFIC Check any past surgical history:

□ Prostate Surgery ____
□ Penile Surgery ____
□ Prostate Biopsy ____
□ Testicle Removal ____
□ Vasectomy ____
□ Other:
_____

Check any family history of illness:

Adopted? N Y	Father	Mother	Brother	Sister	Son	Daughter	In Family
Deceased							
Diabetes							
Enlarged Prostate							
High Blood Pressure							
Kidney Stones							
Kidney Failure							
Prostate Cancer							
Stroke							
UTIs							
Cancer							
Other							

Social History:

MARITAL STATUS: S M D W **Children?** N Y # of Sons _____ # of Daughters _____

TABACCO USE: □ Current □ Former □ Never Passive Smoke Exposure? N Y

_____ Packs per day _____ Years Used Have you tried to quit? N Y

SMOKER STATUS: □ Current, Every Day □ Former Smoker □ Current, Some Day Smoker □ Never

Have you tried to quit? N Y Year quit: _____

CAFFEINE: N Y Type: _____ / _____ Amount of caffeine per day: _____

ALCOHOL: N Y Formerly Type: _____ Frequency: _____ Amount: _____ Last Drink: _____

IMMUNIZATIONS: Tetanus N Y _____ (Date) **Influenza** N Y _____ (Date) **Pneumonia** N Y _____ (Date)

COLONOSCOPY: N Y Date _____ **MAMMOGRAM:** N Y Date _____

Review of Systems: Check if you are currently experiencing any of the following symptoms. Please mark YES or NO for each section.

Constitutional:

No	Yes	
□	□	Chills
□	□	Fever
□	□	Fatigue/Malaise
□	□	Night Sweats
□	□	Weight Loss

Cardiovascular:

No	Yes	
□	□	Chest Pain
□	□	Palpitations
□	□	Arrhythmia

Hema\Lymph:

No	Yes	
□	□	Bleeding Tendency
□	□	Easy Bruisability
□	□	Swollen Glands
□	□	Blood Clot

Musculoskeletal:

No	Yes	
□	□	Weakness
□	□	Pain
□	□	Arthritis

Physiological:

No	Yes	
□	□	Anxiety
□	□	Depression
□	□	Decreased Libido

Ears:

No	Yes	
□	□	Hearing Loss
□	□	Ringing in Ears

Nose:

No	Yes	
□	□	Sinus Infection
□	□	Sleep Apnea

Throat:

No	Yes	
□	□	Soreness
□	□	Dry Mouth
□	□	Ulcers

Eyes:

No	Yes	
□	□	Blurred Vision
□	□	Double Vision
□	□	Cataracts
□	□	Glaucoma

Gastrointestinal:

No	Yes	
□	□	Nausea
□	□	Diarrhea
□	□	Reflux
□	□	Vomiting
□	□	Bloody Stool
□	□	Constipation

Endocrine:

No	Yes	
□	□	Diabetes
□	□	Heat/Cold Intolerance
□	□	Hair Loss

Skin

No	Yes	
□	□	Dry Skin
□	□	Itching
□	□	Rash
□	□	Peeling
□	□	Skin Discoloration

Respiratory:

No	Yes	
□	□	Shortness of Breath
□	□	Chronic Coughing
□	□	Wheezing
□	□	Coughing Blood

Genitourinary:

No	Yes	
□	□	Painful Urination
□	□	Urinary Urgency
□	□	Nighttime Urination
□	□	Blood in Urine
□	□	Leakage of Urine
□	□	Decreased Stream
□	□	Flank Pain
□	□	Urinary Retention

Immunological/Allergy:

No	Yes	
□	□	Medications
□	□	Hives
□	□	Food Intolerance
□	□	Contrast Dye

Neurological:

No	Yes	
□	□	Headaches
□	□	Numbness
□	□	Dizziness
□	□	Paralysis
□	□	Confusion/ Memory Loss