ATLANTIC COAST UROLOGY, PA
UROLOGY AND GENITOURINARY SURGERY
Matthew S. Tobin, MD, FACS
Medea A. Rueda-Macaluso, ANP

Please kindly provide us with your email address. Thank you!

Patient Name:

____

Email Address:

____

Date of Birth:

____

ATLANTIC COAST UROLOGY, PA
ADULT AND PEDIATRIC
UROLOGY AND GENITOURINARY SURGERY

PATIENT HISTORY

WELCOME TO OUR PRACTICE

As a new patient, please fill out the information found below to the best of your ability. A few minutes of your time carefully answering the following questions will help our urologist accurately access your problem, give better care and assist in proper insurance submission.

Patient# ____________ Physician ____________ Today's Date ____________

Patient Name ____________ Age ______ Date of Birth ____________

Chief Complaint (reason for visit) ____________

HISTORY OF PRESENT ILLNESS

Location ____________
(Where is problem or pain?)

Quality ____________
(Example abnormal color, sharp, dull or constant, etc.)

Severity ____________
(How severe is problem or pain on a scale of 1-10, 10 being the most severe)

Duration ____________
(When did problem or pain start?)

Timing ____________
(Does problem or pain occur at a specific time?after activity,eating,etc.)

Context ____________
(Where & what were you doing at onset of problem or pain?)

Associated Signs & Symptoms ____________
(What other associated problems have you been having?)

Modifying Factors ____________
(What makes problem or pain worse or better?)

PATIENT MEDICAL & SOCIAL HISTORY

PATIENT MEDICAL HISTORY: Have you ever had the following (circle "yes" or "no", leave blank if uncertain):

Measles	Yes No	Arthritis	Yes No	Mitral Valve Prolapse	Yes No	Blood or Plasma Transfusions	Yes No
Mumps	Yes No	Venereal Disease	Yes No	Hernia	Yes No	High or Low Blood Pressure	Yes No
ChickenPox	Yes No	Anemia	Yes No	Asthma	Yes No	ANY OTHER DISEASES (please list)	
Whooping Cough	Yes No	Bladder Infection	Yes No	AIDS or HIV+	Yes No		
Scarlet Fever	Yes No	Epilepsy	Yes No	Stroke	Yes No		
Diphtheria	Yes No	Hepatitis	Yes No	Ulcer	Yes No		
Smallpox	Yes No	Tuberculosis	Yes No	Thyroid Disease	Yes No		
Pneumonia	Yes No	Diabetes	Yes No	Kidney Disease	Yes No		
Rheumatic fever	Yes No	Cancer	Yes No	DATE OF LAST CHEST X-RAY ______		DATE OF LAST MAMMOGRAM (female) ______	
Heart Disease	Yes No	Polio	Yes No				

Do you have any artificial joints, heart valves, heart pacemaker or defibrillator? ____________

MEDICATIONS: *(Include prescription, nonprescription and dosages)* ____________

ALLERGIES: *(Include allergies to medication, Iodine, X-ray contrast material, shellfish, etc.)* ____________