FEMALE UROLOGY of NASHVILLE, P.C.
ABEL, ALLEN, SCARPERO

New Patient Registration Form

t: 855- 354-4440 | f: 615-577-3082 | 330 23rd Avenue North, Suite 602 | Nashville, TN 37203

PATIENT INFORMATION

PATIENT NAME _____ BIRTH DATE _____ SOCIAL SEC. # _____ SEX: M F

SPOUSE'S NAME _____ BIRTH DATE _____ SOCIAL SEC. # _____ SEX: M F

CURRENT ADDRESS _____
STREET CITY STATE ZIP

CELL PHONE ( ) _____ HOME PHONE ( ) _____ EMAIL _____

IF PATIENT IS A CHILD:

PARENT/GUARDIAN NAME _____ BIRTHDATE _____ SSN _____

ADDRESS _____ PHONE _____

OTHER PARENT/GUARDIAN NAME _____ BIRTHDATE _____ SSN _____

ADDRESS _____ PHONE _____

ADDITIONAL INFORMATION

REFERRING M.D. _____ PHONE _____ ADDRESS _____

PRIMARY CARE PHYSICIAN _____ PHONE _____ ADDRESS _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT _____ RELATIONSHIP _____

_____ _____
PRIMARY NUMBER SECONDARY NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INS. CO. _____

POLICYHOLDER _____

DOB: _____

PATIENT RELATIONSHIP TO POLICY HOLDER:
☐ SELF ☐ SPOUSE
☐ CHILD ☐ OTHER_____

MEMBER ID # _____

GROUP ACCT #_____

EFFECTIVE DATE_____

PHONE # TO VERIFY BENEFITS_____

PHONE # FOR PRECERTIFICATION_____

SECONDARY INSURANCE

NAME OF INS. CO. _____

POLICYHOLDER _____

DOB: _____

PATIENT RELATIONSHIP TO POLICY HOLDER:
☐ SELF ☐ SPOUSE
☐ CHILD ☐ OTHER _____

MEMBER ID # _____

GROUP ACCT #_____

EFFECTIVE DATE_____

PHONE # TO VERIFY BENEFITS_____

PHONE # FOR PRECERTIFICATION_____

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Medical History

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Patient Name: _____ **Date of Birth:** _____ **Appt Date** _____

Primary Care Physician: _____ **Referring Physician** _____

What is the main reason for your visit: _____

Check any *past* medical problems:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Injury or Surgery
- ☐ Cancer: Type_____
- ☐ Chronic UTIs
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: # of years ___
- ☐ Diverticulitis
- ☐ Enlarged Prostate
- ☐ Fecal Incontinence
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel Synd
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neurologic Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Radiation
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Stroke or Head Injury
- ☐ Thryroid Disease
- ☐ Valvular Heart Disease

List any medical diagnoses or problems not listed above:

_____

_____

Current Medications

List all medications you currently take including vitamins, herbal supplements and over-the-counter medications. If needed, attach an additional sheet.

Name of Medication	Dose (mg)	Reason for taking medication	Physician prescribing if other than Primary MD
1.			
2.			
3.			
4.			
5.			

Pharmacy

Local pharmacy most frequently used for prescriptions:

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip: _____

Mail-order pharmacy used for prescriptions:

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip: _____

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Patient Name: _____ **Date** _____

Allergies

List any medical or environmental allergies you have (ex. Medications, food, dyes, chemicals).

Name of Allergen	Type of reaction
1.	
2.	
3.	
4.	

Past Surgeries

Include all surgery in your lifetime. Attach extra sheet if necessary.

Type of Surgery	Date (approximate)	Hospital or City (if known)
1.		
2.		
3.		
4.		
5.		

Check any FAMILY HISTORY of illness:

☐ Diabetes	☐ Bladder Leakage	☐ Ovarian Cancer
☐ High Blood Pressure	☐ Vaginal Prolapse	☐ Uterine Cancer
☐ Kidney Failure	☐ Enlarged Prostate	☐ Breast Cancer
☐ Multiple Sclerosis	☐ Kidney Stones	☐ Prostate Cancer
☐ Stroke	☐ Urinary Tract Infections	☐ Cancer, Other

Social History:

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Tobacco Use: ☐ Never ☐ Former ☐Current

Caffeine: ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No ☐ Formerly

Water Intake: _____/per day ☐Glasses ☐Ounces ☐Liters

Sleep: _____hours per day

Occupation: ☐Retired ☐_____

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Patient Name: _____ **Date** _____

Review of Systems

Check if you are currently experiencing any of the following symptoms. Please mark Yes or No for each selection.

Constitutional

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Weight gain over 10 lbs	☐ Yes	☐ No
Weight loss under 10 lbs	☐ Yes	☐ No

Neurological (nervous system)

Seizures	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Numbness in extremity	☐ Yes	☐ No
Weakness in extremity	☐ Yes	☐ No
Loss of balance	☐ Yes	☐ No
Frequent falls	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

Endocrine (internal glands)

Excessive thirst	☐ Yes	☐ No
Cold or heat intolerance	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea vomiting	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in stools	☐ Yes	☐ No
Fecal Leakage	☐ Yes	☐ No

Cardiovascular

Chest pain, pressure	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No

Integumentary (skin problems)

Unexplained rash	☐ Yes	☐ No
Frequent boils	☐ Yes	☐ No

Musculoskeletal

Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Muscle Weakness	☐ Yes	☐ No

Respiratory (lungs)

Wheezing	☐ Yes	☐ No
Frequent coughing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No

Hematologic / Lymphatic

Swollen lymph glands	☐ Yes	☐ No
Bleeding tendency	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No

Genitourinary (urinary and genital)

Frequent UTIs	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Urgent urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Straining to urinate	☐ Yes	☐ No
Interrupted urine flow	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Incomplete emptying	☐ Yes	☐ No
Sexual Dysfunction	☐ Yes	☐ No

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
History glaucoma	☐ Yes	☐ No
Untreated cataracts	☐ Yes	☐ No
Retinal disease	☐ Yes	☐ No

Psychological

Depression	☐ Yes	☐ No
Loss of general interest	☐ Yes	☐ No
Severe anxiety	☐ Yes	☐ No

Height (inches) _____

Weight (lbs)_____