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

New Patient Registration Form

t: 615-678-5544 | f: 615-739-5610 | 310 25TH Avenue North, Suite 202 | 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** _____

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)	How often is the medication taken	Reason for taking medication	Physician prescribing
1.				
2.				
3.				
4.				
5.				

Pharmacy

List pharmacy most frequently used for prescriptions.

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip: _____

Allergies

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

Name of Allergen	Type of reaction	Approximate Date
1.		
2.		
3.		
4.		
5.		

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.		

Other Hospitalizations

Include all non surgical hospitalizations.

Reason for Hospital Stay	Date (approximate)	Hospital or City (if known)
1.		
2.		
3.		
4.		
5.		

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Check any *past* medical problems:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer; Type_____
- ☐ Chronic UTIs
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Chrohn's
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: # of years ____
- ☐ Diverticulitis
- ☐ Enlarged Prostate
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neurologic Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thryroid Disease
- ☐ Valvular Heart Disease

Other: _____

Check any family history of illness:

	Adopted? Y / N	Father	Mother	Brother	Sister	Grandparent	Son	Daughter	Runs in Family
☐	Diabetes								
☐	Enlarged Prostate								
☐	High Blood Pressure								
☐	Kidney Stones								
☐	Kidney Failure								
☐	Prostate Cancer								
☐	Stroke								
☐	Urinary Tract Infections								
☐	Cancer, Other								
☐	Other								

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Children? ☐ Yes ☐ No # of Sons _____ # of Daughters ____

Tobacco Use: ☐ Current ☐ Former ☐ Never Type: _____ Units per day / _____day / Years Used _____years

Have you tried to quit? ☐ Yes ☐ No Year quit: _____ Passive Smoke Exposure: ☐ Yes ☐ No

Smoker Status:
- ☐ Current, Every Day
- ☐ Current, Some Day Smoker
- ☐ Current status unknown
- ☐ Former Smoker
- ☐ Never Smoked
- ☐ Unknown if ever smoked

Caffeine: ☐ Yes ☐ No Type: _____ Amt per day:_____

Alcohol: ☐ Yes ☐ No ☐ Formerly Type:_____ Frequency:_____ Amount:____ Last Drink:_____

Immunizations:

- Tetanus ☐ Yes ☐ No Date: ____ / ____ / ____
- Influenza ☐ Yes ☐ No Date: ____ / ____ / ____
- Pneumonia ☐ Yes ☐ No Date: ____ / ____ / ____

☐ ☐

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

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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
Indigestion / Heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in stools	☐ Yes	☐ No

Cardiovascular

Chest pain, pressure	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Calf pain with exercise	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Wake up breathless	☐ Yes	☐ No
Swelling in legs / ankles	☐ Yes	☐ No

Integumentary (skin problems)

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

Musculoskeletal

Joint pain	☐ Yes	☐ No
Which joint_____		
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Recent *or* Chronic		
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

Genitourinary (urinary and genital)

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
Erectile dysfunction	☐ Yes	☐ No

Eyes

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

Ear/Nose/Throat/Mouth

Ear infections	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No
Sinus allergies	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No

Psychological

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

Height (inches) _____

Weight (lbs)_____