UROLOGY ASSOCIATES of Green Bay

General Urology Intake Form

Patient Name: _____ DOB: _____

Date of Visit: ___/___/___ **Primary Care Physician**: _____

Chief Complaint: Briefly describe what conditions bring you to see the urologist	History of Present Illness: **When did you first notice this condition?**

Oncologic History (Please check if **YOU** have ever been diagnosed with any of the following)

	Yes		**Yes**		**Yes**
Bladder Cancer		Breast Cancer		Penile Cancer	
Cervical Cancer		Kidney Cancer		Uterine Cancer	
Prostate Cancer		Testicular Cancer		Other Cancer	

Family History (Please check if an immediate family member has ever been diagnosed with any of the following)

	Yes		**Yes**		**Yes**
Bladder Cancer		Breast Cancer		Penile Cancer	
Cervical Cancer		Kidney Cancer		Uterine Cancer	
Prostate Cancer		Testicular Cancer		Other Cancer	

Social History (Please check the appropriate responses)

Sexually Active: **Yes or No**

Birth Control/Protection: **Yes or No**

Type: Surgical (vasectomy, tubal ligation, hysterectomy) or Non-surgical

Do you currently smoke: **Yes or No** Amount Smoked _____ Years Smoked _____

Past Smoking History? _____ Quit Date _____

Do you drink Alcohol: **Yes or No**

	How Many Per Day:	**How Many Per Month:**
Glasses of Wine	_____	_____
Cans of Beer	_____	_____
Shots of Liquor	_____	_____

Caffeine Consumption: **Yes or No** How Many Per Day _____

Drug Use: **Yes or No** Use per Week _____ Type: ☐ Marijuana ☐ Methamphetamines ☐ Cocaine ☐ IV ☐ Other

Additional comments and Explanations:

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