***RWJ BARNABAS HEALTH***

***PARTNERS IN UROLOGY OF NJ***

***453 WILLIAM STREET SOMERVILLE, NJ 08876***

***Neel Shah, M.D. – Nitin Patel, M.D.***

***Adam Kane, APN – Hyejin Kim, PA***

## ***PATIENT DEMOGRAPHICS***

**Date of visit**: _____ **Physician**: _____

**Name (First & Last):** _____ **Preferred Name**: _____

**Birth Sex**: Male __ Female __ **Gender Identity:** Male __ Female __ Other (specify) _____

**D.O.B**:_____ **Age**: ____ **Language:** English __ Spanish __ Other (specify) _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Preferred Phone:** _____ Home ___ Mobile ___

**Alternate Phone:** _____ Home ___ Mobile ___

Can we send appointment confirmation text messages? Yes ___ No ___

**Email:** _____

**Primary Physician:** _____ **Office Number:** _____

**Additional doctors involved in your care:** _____

**How did you hear about our practice?** _____

**Emergency contact (Name & Number):** _____

Relation to patient: _____

**Insurance:** _____

Subscriber name (if not the patient): _____

Subscriber D.O.B. (if not the patient): _____

Relation to Patient: _____

**Secondary Insurance:** _____

Subscriber: Self ___ As listed above ___

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**Name:** _____ **D.O.B:** _____

**Reason for visit:**

_____

_____

**Past Medical History (Y/N):**

___AFIB/Arrhythmia

___Arthritis

___Back Pain

___Bleeding/Clot Disorder

___Breathing Problems

___Cancer _____

___Colon Problems

___ Chronic Kidney Disease

___Diabetes Mellitus

___ Deep Vein Thrombosis

___ Gastric Reflux

___ Glaucoma

___Gout

___Heart Attack

___Heart Disease

___Heart Stent

___Hepatitis

___Hernia

___Hypertension

___History of Chemo

___History of Radiation

___Kidney Failure

___Kidney Stone

___Liver Disease

___Lung Disease

___Neuropathy

___Obstructive Sleep Apnea

___Pacemaker

___Pulmonary Embolism

___Seizure Disorder

___Stroke/TIA

___Thyroid Disease/hyperparathyroidism

___Ulcers

Other Medical Issues:

_____

_____

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**Surgical History:** ____None

| Y/N | Procedure | Date | Y/N | Procedure | Date |
|---|---|---|---|---|---|
| | Appendectomy (Appendix) | | | Kidney Stone – ESWL/URS | |
| | Brain | | | Knee Replacement | |
| | Bladder / Bladder Biopsy | | | Lung | |
| | Bowel / Colon | | | Nephrectomy (Kidney removal) | |
| | Cholecystectomy (Gallbladder) | | | Prostatectomy | |
| | Cardiac: Valve/Stent/Pacemaker | | | Prostate Biopsy – Neg. / Positive | |
| | Green Light Laser (Prostate) | | | Rezum (Prostate) | |
| | Hernia | | | Shoulder | |
| | Hip Replacement | | | TURP (Prostate) | |
| | Hysterectomy | | | Urolift (Prostate) | |

Additional Surgical History:

_____

**Family History:**

M- Mother, F- Father, S- Sister, B- Brother, G- Grandparent, A- Aunt, U- Uncle, C- Cousin

Bladder Cancer: _____ Kidney Stones: _____

Breast Cancer: _____ Ovarian Cancer: _____

Colon Cancer: _____ Prostate Cancer: _____

Diabetes: _____ Pancreatic Cancer: _____

Heart Disease: _____ Testicular Cancer: _____

Kidney Cancer: _____ Other: _____

Kidney Disease: _____ _____

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**Medications:** ____None

| Medication | Dosage | Frequency | Medication | Doseage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Pharmacy (Name, Street Name, Town): _____

Pharmacy (Mail order): _____

**Drug Allergies or Reactions to Medications/Food/ Other agents:** ___ No ___ Yes (Please list)

_____

**Social History:**

Marital Status: _____ Occupation: _____

Height (feet & inches): _____ Weight (lbs.): _____

Tobacco Use:

None: ____ Yes: ____ How Much: _____ Quit Date: _____

Alcohol Use:

None: ____ Yes: ____ How Much: _____ Quit Date: _____

Recreational Drug Use:

None: ____ Yes: _____

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***Review of Symptoms***

| **General** | | **Respiratory** | |
|---|---|---|---|
| Fever | Y / N | Wheezing | Y / N |
| Chills | Y / N | Cough | Y / N |
| Weakness | Y / N | Shortness of breath | Y / N |
| Fatigue | Y / N | **Genitourinary** | |
| **Ears/Eyes/Nose/Throat** | | Urine retention | Y / N |
| Eye discharge | Y / N | Painful urination | Y / N |
| Hearing loss | Y / N | Urinary frequency | Y / N |
| Sore throat | Y / N | Blood in urine | Y / N |
| Sinus problems | Y / N | **Skin** | |
| **Neurologic** | | Rash | Y / N |
| Confusion | Y / N | Pallor | Y / N |
| Numbness/tingling | Y / N | **Musculoskeletal** | |
| Dizziness | Y / N | Joint pain | Y / N |
| Headache | Y / N | Neck pain | Y / N |
| **Cardiovascular** | | Back pain | Y / N |
| Chest Pain | Y / N | **Hematologic** | |
| Palpitations | Y / N | Adenopathy (swollen glands) | Y / N |
| **Gastrointestinal** | | Blood clotting problems | Y / N |
| Abdominal Pain | Y / N | Bruising Tendency | Y / N |
| Nausea/vomiting | Y / N | **Psychologic** | |
| Constipation | Y / N | Anxiety | Y / N |
| Diarrhea | Y / N | Hallucinations | Y / N |
| **Skin** | | **Endocrine** | |
| Rash | Y/N | Cold intolerance | Y/N |
| Pallor | Y/N | Heat intolerance | Y/N |

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I understand that as part of my healthcare, Partners in Urology of NJ, originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, and to communicate with other healthcare providers.

The Notice of Privacy Practices provides specific information and complete description of how my private health information (PHI) may be used and disclosed. I have been provided a copy of our access to the Notice of Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to restrict the use and/or disclosure of my PHI for treatment, payment or healthcare operations and that Partners in Urology of NJ is not required to agree to the restrictions requested. I may revoke this consent at any time, and consent is valid until revoked by me in writing.

If you want the doctors to have access to disclose your PHI to your spouse or any other person during your treatment, please list and sign below.

I agree to allow Partners in Urology of NJ to disclose my PHI (including date/time of appointments) to:

| **Name** | **Relation & phone number** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

___ Myself only, no other family member

This does not serve as an Authorization to Release Medical Record

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I have been provided and have reviewed Partners in Urology of NJ's Notice of Privacy Practices.

_____

Print name of Patient or Legal Representative

_____ _____

Signature of Patient or Legal Representative Date