Neill Borland, MD
Murray Goldberg, MD
Stephanie Cindric, ARNP
Joseph Tojar, PA-C

Demographic Information

Name: ______________________________ DOB: ______________ Sex: **M** **F**

Primary Address: ____
(Street and Apt #) (City) (State) (Zip)

Secondary Address: ____
(Street and Apt #) (City) (State) (Zip)

Home Number: (   ) ____________ (   ) None Cell Number: (   ) ____________

Email Address: ______________________________ (used only for patient portal)

Patient Guardian (if applicable): ______________________________ DOB: ______________

If you are the legal guardian for this patient, please provide the supporting documentation to the Front Office.

Emergency Contact: ______________________ Phone Number: (   ) ____________

Relationship to Patient: ______________________

Primary Insurance: ______________________ ID#: ______________________

Cardholder Name and DOB (if different from the patient): ______________________________

- -

Secondary Insurance: ______________________ ID#: ______________________

Cardholder Name and DOB (if different from the patient): ______________________________

PCP: ______________________ Referred by: ______________________

How did you hear about us? ______________________________

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring healthcare provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assessment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductible, co-insurance and copays. I understand that I am financially responsible for any charges not covered by my insurance, and if I fail to give updated, current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged $35.00. If we determine your account should be placed with an outside collection agency, or an attorney, you will be assessed with an additional 50% of the balance due.

Patient/Guardian Signature: ______________________________ Date: ______________

Urologic Physicians and Surgeons, P.A.
a division of Urology Group of Florida

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History and Intake Form

Patient Name: ______________________ Date of Birth: __________

Primary and/or Referring Physician: ______________________

Pharmacy Location and Contact: ______________________

Main Reason for your visit: ______________________

Social History:

Do you smoke? YES NO If "YES", how many packs per day? __________

Have you previously smoked? YES NO How many packs per day did you smoke? __________
When did you stop? __________ In years, how long did you smoke? __________

Do you drink alcoholic beverages? YES NO Occasionally
If "YES", how many on a daily basis? __________

Past Medical History: (Please check "YES" for all that apply)

	YES	NO		YES	NO		YES	NO
Anxiety	☐	☐	Coronary Artery Disease	☐	☐	High Cholesterol	☐	☐
Arthritis	☐	☐	Depression	☐	☐	Hyperthyroidism	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Hypothyroidism	☐	☐
Atrial Fibrillation	☐	☐	End Stage Renal Disease	☐	☐	Leukemia	☐	☐
Bone Marrow Transplant	☐	☐	GERD	☐	☐	Lung Cancer	☐	☐
BPH	☐	☐	Hearing Loss	☐	☐	Lymphoma	☐	☐
Breast Cancer	☐	☐	Heart Attack	☐	☐	Prostate Cancer	☐	☐
Colon Cancer	☐	☐	Hepatitis	☐	☐	Radiation Treatment	☐	☐
COPD	☐	☐	High Blood Pressure	☐	☐	Seizure	☐	☐
			HIV/AIDS	☐	☐	Stroke	☐	☐

Other: ______________________

Please list all surgeries you have had and when they occurred:

☐ No Surgeries

☐ Bladder Surgery: ______________________

☐ Kidney Surgery: ______________________

☐ Joint Replacement: ______________________

☐ Cardiovascular: ______________________

☐ Prostate Surgery/Biopsy: ______________________

☐ Scrotal Surgery: ______________________

Please list all other surgeries, if not listed previously:

____
____
____
____
____

Urologic Disease History: (Please check "YES" for all that apply)

	YES	NO		YES	NO		YES	NO
Blood in Urine	☐	☐	Hydronephrosis	☐	☐	Renal Tubular Acidosis	☐	☐
Cancer (Bladder)	☐	☐	Infertility	☐	☐	Sexual Dysfunction	☐	☐
Cancer (Kidney)	☐	☐	Stones (Urolithiasis)	☐	☐	STD/STI	☐	☐
Cancer (Penile)	☐	☐	Neurogenic Bladder	☐	☐	Undescended Testis	☐	☐
Cancer (Prostate)	☐	☐	Painful Urination (Dysuria)	☐	☐	Urethral Stricture	☐	☐
Cancer (Testicular)	☐	☐	Polycystic Kidney Disease	☐	☐	Urinary Incontinence	☐	☐
Elevated PSA	☐	☐	Priapism	☐	☐	Urinary Retention	☐	☐
Genitourinary Trauma	☐	☐	Prostatitis	☐	☐	Urinary Tract Infection	☐	☐
			Renal Insufficiency	☐	☐	Vesicoureteral Reflux	☐	☐

Other: ____

Family History: (Please check "YES" for all that apply and indicate Family Member)

	YES	NO	
Kidney Cancer	☐	☐	Who: ______________
Bladder Cancer	☐	☐	Who: ______________
Prostate Cancer	☐	☐	Who: ______________
Genital Cancer	☐	☐	Who: ______________
Kidney Stones	☐	☐	Who: ______________
Kidney Disorders	☐	☐	Who: ______________
Bleeding Disorders	☐	☐	Who: ______________
Heart Disease	☐	☐	Who: ______________

Please list any allergies and type of reaction:

☐ No Known Drug Allergies

Allergies	Reaction

Review of Systems: (Please check all POSITIVE complaints.) ☐ No Positive Complaints

Constitutional: ☐Chills ☐Fever ☐Weight loss
Cardio: ☐Chest Pains ☐Swollen ankles ☐High Blood Pressure
Eyes: ☐Blurred Vision ☐Eye Pain ☐Worsening Eyes
Skin: ☐Rash ☐Lesions ☐Psoriasis
Allergies: ☐Drug ☐Food ☐Seasonal
Musculoskeletal: ☐Arthritis ☐Cramps ☐Gout
Neurological: ☐Dizzy ☐Headache ☐Seizures
ENT: ☐Sore Throat ☐Ear Infections ☐Sinus Problems
Endocrine: ☐Thirst ☐Tired ☐Hot/Cold
Respiratory: ☐Asthma ☐Shortness of Breath ☐Cough
GI: ☐Heartburn ☐Diarrhea ☐Constipation
Hematologic: ☐Anemia ☐Easy Bleeding ☐Swollen Glands
Kidney Disease: ☐Renal Failure ☐Transplant
Psychologic: ☐Anxiety ☐Depression ☐Suicidal Thoughts

Other Conditions: ______________________________

Please select the most appropriate answer to the following questions.

	Never	Rarely	Sometimes	Half the Time	Often	Always
How often do you have difficulty in postponing urination?	☐	☐	☐	☐	☐	☐
How often do you leak urine during activities like coughing, sneezing, lifting or exercise?	☐	☐	☐	☐	☐	☐
How often do you have a strong need to empty your bladder before you start to leak urine?	☐	☐	☐	☐	☐	☐
How often do you lose (leak) urine while you are sleeping?	☐	☐	☐	☐	☐	☐
How often do you lose (leak) urine when you do not want to?	☐	☐	☐	☐	☐	☐
How many times do you urinate during the day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5+
How many times do you get up at night to urinate?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5+

Have you received treatment for urinary incontinence (leakage) in the past? ☐ YES ☐ NO

Do you wear a form of protection for your leakage? ☐ YES ☐ NO If "YES", how many pads per day? ____________

Do you see blood in your urine? ☐ YES ☐ NO

How would you feel if you had to live with your urinary condition the way it is now, no better and no worse, for the rest of your life?

☐ Delighted ☐Pleased ☐Mostly Satisfied ☐Mixed ☐Unhappy ☐Terrible

Please, turn this page over to continue.

Please list any medications and complete the following table to the best of your abilities:
(If you need more space, we will gladly provide you with another sheet of paper.)

□ No Medications

Medication Name	Dose	Frequency	Route (i.e., Oral, topical, injection, etc.)

I hereby attest that the information provided on this form is accurate and truthful.

Patient/Guardian Signature

Date

Patient/Guardian Printed Name