UACC
Urology Associates
Of Cape Cod, P.C.

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508-862-6358
www.UACC.cc

PATIENT INFORMATION

DATE: _____

NAME:_____,_____**AGE:**_____**D.O.B.**____/____/____
Last **First** **M.I.**

HOME ADDRESS:_____,_____,_____, _____
Street Address **City / Town** **State** **Zip Code**

MAILING ADDRESS:_____,_____,_____, _____
(If Different From Home Address)

E-MAIL ADDRESS: _____

PRIMARY PHONE:_____**SECONDARY PHONE** _____

CURRENT OR FORMER OCCUPATION: _____

EMERGENCY CONTACT:_____**CONTACT PHONE NUMBER:** _____

RELATIONSHIP TO PATIENT: _____

MARITAL STATUS (Circle One): Single Married Divorced Widowed

NAME OF SPOUSE:_____

SOCIAL SECURITY NUMBER: _____

PHARMACY NAME:_____**ADDRESS:**_____

PRIMARY CARE PHYSICIAN:_____**PHONE #** _____

PLEASE BRING ALL INSURANCE CARDS AND A PHOTO IDENTIFICATION TO EVERY APPOINTMENT. ALL CO-PAYMENTS ARE EXPECTED AT TIME OF VISIT

PATIENT HISTORY

Reason for your visit: _____

Height:_____ **Weight:** _____

Medications: **List *all* your current medications and dosages or bring a list with you:**

Start Date	Drug Name & Strength	Dose (pills, units, puffs, drops)	When to Take	Purpose / Reason

Medical:

List *all* serious illnesses in your *personal* lifetime. (Example: diabetes, stroke, hypertension, breathing, heart problems, angina, prostate cancer, bladder cancer etc..): _____

_____

List *all* allergies to medications (or other substances): _____

_____

Surgical:

List *all* surgeries in your *personal* lifetime with appropriate dates: _____

_____

Family History

List *all* serious illnesses in your immediate family: (Example: diabetes, stroke, hypertension, emphysema, heart attack, angina, cancer, prostate cancer, bladder cancer etc...): _____

_____

Smoking: **Are you a:** ❑ **Current smoker** ❑ **Former smoker** ❑ **Non-smoker**

***If You are currently smoking:* Would you like information on quitting? ❑ yes ❑ no**

How many cigarettes do you smoke per day?_____ **How long have you been smoking?** _____

***If you are a former smoker:* How long did you smoke for?**_____ **When did you quit?** _____

Do you *now* or have you *had* any problems related to the following systems? Please circle Y = yes, N = no.
Please explain all YES answers in space provided.

GENITOURINARY

PAINFUL URINATION	Y	N
HESITANCY	Y	N
FREQUENCY	Y	N
URGENCY	Y	N
INCONTINENCE	Y	N
BLOOD IN URINE	Y	N
TESTICLE PAIN / LUMP		
OTHER_____	Y	N

_____

_____

_____

_____

_____