

RWJ BARNABAS HEALTH
PARTNERS IN UROLOGY OF NJ
453 WILLIAM STREET SOMERVILLE, NJ 08876
Anthony Catanese, M.D – Neel Shah, M.D. – Nitin Patel, M.D.
Adam Kane, APN

PATIENT DEMOGRAPHICS

Date: _____

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):

- | | |
|---|--|
| <input type="checkbox"/> AFIB/Arrhythmia | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> History of Chemo |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> History of Radiation |
| <input type="checkbox"/> Bleeding/Clot Disorder | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Kidney Stone |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thyroid Disease/hyperparathyroidism |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Stent | Other Medical Issues: |
| <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> Hernia | _____ |

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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
_____	_____
_____	_____
_____	_____
_____	_____
<input type="checkbox"/> 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