***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 \_\_\_Hypertension

\_\_\_Arthritis \_\_\_History of Chemo

\_\_\_Back Pain \_\_\_History of Radiation

\_\_\_Bleeding/Clot Disorder \_\_\_Kidney Failure

\_\_\_Breathing Problems \_\_\_Kidney Stone

\_\_\_Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Liver Disease

\_\_\_Colon Problems \_\_\_Lung Disease

\_\_\_ Chronic Kidney Disease \_\_\_Neuropathy

\_\_\_Diabetes Mellitus \_\_\_Obstructive Sleep Apnea

\_\_\_ Deep Vein Thrombosis \_\_\_Pacemaker

\_\_\_ Gastric Reflux \_\_\_Pulmonary Embolism

\_\_\_ Glaucoma \_\_\_Seizure Disorder

\_\_\_Gout \_\_\_Stroke/TIA

\_\_\_Heart Attack \_\_\_Thyroid Disease/hyperparathyroidism

\_\_\_Heart Disease \_\_\_Ulcers

\_\_\_Heart Stent Other Medical Issues:

\_\_\_Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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) |  |

**Surgical History:** \_\_\_\_None

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