UNIVERSITY UROLOGISTS

a division of UGF

DAVID WEINSTEIN, M.D., F.A.C.S.
LEONARD KAUFMAN, M.D., F.A.C.S.
DAVID S. MEINBACH, M.D., F.A.C.S.

PATIENT NAME: _____ **DATE:** ____ /____/ _____ **MED REC #:** _____

DATE OF BIRTH: ____ /____ /____ **AGE:** _____ **HEIGHT:** ____ **FT** ____ **IN** **WEIGHT:** _____ **LBS**

STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY AND STATE		ZIP CODE	SOCIAL SECURITY #
PATIENT'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?		HOME PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			CELL PHONE NO.
SPOUSE'S / PARTNER'S NAME	NUMBER OF CHILDREN AND AGES			MARITAL STATUS: S M DP W D
SPOUSE'S / PARTNER'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE	
WHO CAN WE CALL IN AN EMERGENCY OTHER THAN YOUR HOME PHONE:				

NORTHERN ADDRESS:

Street: _____ City: _____ St.: _____ Zip: _____

Name of Referring Physician: _____ Referring Physician's Phone #: _____

Referring Physician's Address: _____

Primary Care Physician (if Different) _____ Phone #: _____

Reason for your visit today: _____ Sex: ❒ Female ❒ Male

Pharmacy Name: _____ **Address:** _____ **City:** _____ **Zip:** _____

Pharmacy Phone #: _____ **Pharmacy Fax #:** _____

GOVERNMENT MANDATED QUESTIONS:

RACE ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander ☐ Other _____ ☐ Declined

PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Other _____ ☐ Declined

ETHNICITY (CHECK APPROPRIATE)

☐ NO, Not Hispanic, Latino, or Spanish Origin ☐ YES, Mexican, Mexican-American or Chicano Origin

☐ YES, Puerto Rican Origin ☐ YES, Cuban Origin ☐ YES, another Hispanic, Latino or Spanish Origin ☐ Declined

Drug Allergies: _____

Other Allergies: Latex ☐ Yes ☐ No _____

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely:

Name of Drug or Supplement:	Strength (mg):	How often (# of times per day)
❒ See attached list		