UAB MEDICINE
MULTISPECIALTY CLINIC
BAPTIST MEDICAL CENTER SOUTH

2119 East South Boulevard
Montgomery, AL. 36116
(334) 613-7070

SOUTH LOCATION Urology
2119 East South Blvd.
Montgomery,AL. 36116
Phone:334-613-7070

NEW PATIENT APPOINTMENT – UROLOGY

_______________________________________, you have an appointment with

☐ Dr. Geoffrey Habermacher ☐ Gary Walker, CRNP
☐ Dr. Travis Dum ☐ Sherry Henning, CRNP

on

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

________________ at ________________ AM PM.

Please bring all of your medications with you to your appointment.

You **must** arrive 30 minutes prior to your appointment.

If you are not able to make this appointment, please call 334-613-7070 as soon as possible. You **must** arrive 30 minutes to your appointment to ensure we are able to see you. Please know your appointment may be rescheduled if you do not arrive on time. On the day of your appointment, please bring the following items with you:

- **Enclosed Paperwork – Please complete all of the enclosed paperwork prior to arriving for your appointment.**
- **Photo identification card.**
- **Co-pay**
- **Insurance Card.**
- **Medication bottles: Please bring the actual bottles for all medications you are currently taking.**

All co-pays are due prior to services rendered

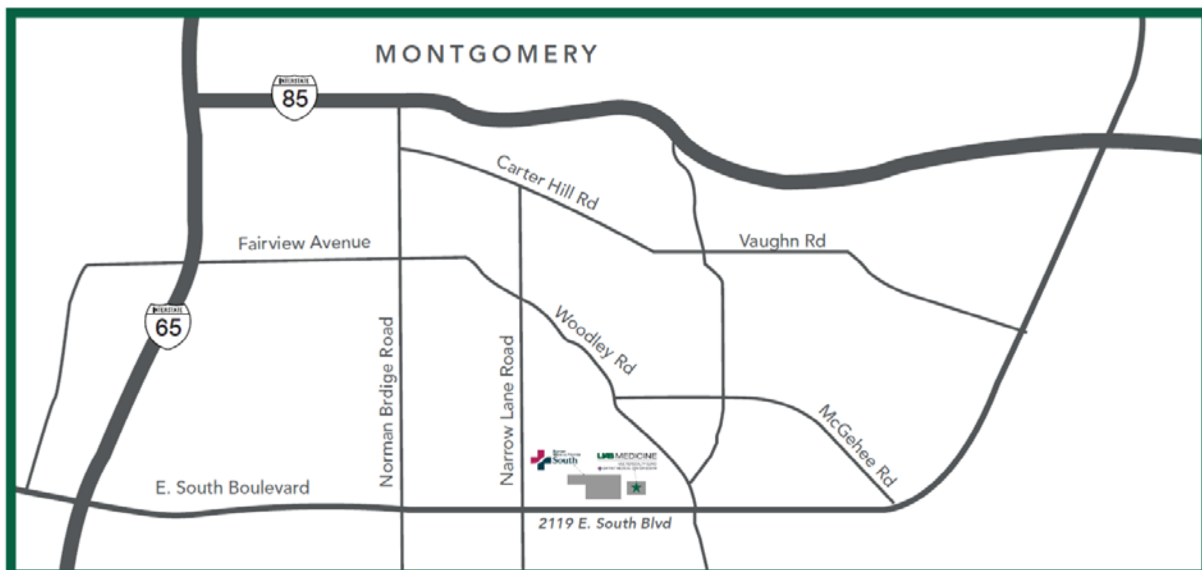
2119 East South Boulevard
Montgomery, AL 36116
(334) 613-7070

NEW PATIENT INFORMATION FORM

Helpful Information & Directions

The UAB Multispecialty Clinic is located on the campus of Baptist Medical Center South. The UAB building is a three-story building located on the right (east) side of the campus, across from the Emergency Room ambulance bays.

2119 East South Blvd.
Montgomery, AL 36116



When you come for your appointment:

- Bring all of your medication in their original containers.
- Bring your insurance card and driver's license or other identification.
- You must arrive at least 30 minutes before your appointment time.
- Don't forget to bring these completed forms with you.

2119 East South Boulevard
Montgomery, AL 36116
(334) 613-7070

Patient Name: ______________________________ Date of Birth: ________________________

What is the reason for your visit today?

____

____

On a scale of 1 – 10, with 10 being the most severe, circle the number that best describes how much this problem is bothering you. 1 2 3 4 5 6 7 8 9 10

Does anything help or make the problem worse? ☐ Yes ☐ No

____

How long does the problem last?

____

Anything else occurring at the same time (Nausea, rash, headache)? ☐ Yes ☐ No

Patient Past Medical History: (Please list any medical conditions either current or past.)

- ☐ Heart Disease
- ☐ Diabetes
- Taking Insulin? ☐ Yes ☐ No
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ HIV/AIDS
- ☐ Hepatitis A / B /C
- ☐ Other:
- ☐ Heart Attack
- ☐ Cancer (Please specify the type)
- ☐ Prostate Cancer
- ☐ Kidney Disease
- ☐ Parkinson's
- ☐ Liver Disease
- ☐ Epilepsy or Seizures
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Depression
- ☐ Dialysis
- ☐ Alzheimer's

____

____

Have you had any surgeries? Please list:

____

____

____

2119 East South Boulevard
Montgomery, AL 36116
(334) 613-7070

Patient Name: ___________________________________ Date of Birth: ___________________________

Please list any medication that you are currently taking:

____

____

____

Do you have any Allergies to medications? Please list:

____

____

Have you used tobacco products?	☐ Yes	☐ No
Do you drink alcoholic beverages?	☐ Yes	☐ No
Do you drink caffeine (soda, coffee, etc.)?	☐ Yes	☐ No
Are you being treated for chronic pain?	☐ Yes	☐ No

Family Medical History: (Please list any medical conditions in your family and specify which family member.)

CONDITION	**FAMILY MEMBER (mother,father, etc.)**	**CONDITION**	**FAMILY MEMBER (mother,father, etc.)**
☐ Heart Disease	__________________	☐ Prostate Cancer	__________________
☐ Diabetes	__________________	☐ Cancer (Type)	__________________
☐ Stroke	__________________	☐ HIV/AIDS	__________________
☐ High cholesterol	__________________	☐ Kidney Disease	__________________
☐ Heart Attack	__________________	☐ Kidney Stones	__________________
☐ HIV/AIDS	__________________	☐ Alzheimer's	__________________
☐ High Blood Pressure	__________________	☐ Dementia	__________________
☐ Other:	__________________		

____

____

____

2119 East South Boulevard
Montgomery, AL 36116
(334) 613-7070

Patient Name: ________________________________ Date of Birth: __________________________

Urology Review of Systems

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

Constitution	**YES**	**NO**	**GU**	**YES**	**NO**
Chills			Difficulty Urinating		
Fatigue			Pain with Urination		
Fever			Urine Leakage		
Unexpected weight change			Flank Pain		
Head, Ears, Neck, Throat	**YES**	**NO**	Frequency		
Facial Swelling			Blood in Urine		
Hearing Loss			Urgency		
Nosebleeds			**Musculoskeletal**	**YES**	**NO**
Congestion			Back Pain		
Sore Throat			Joint Swelling		
Eyes	**YES**	**NO**	Muscle Pain		
Eye Discharge			**Skin**	**YES**	**NO**
Eye Pain			Color Change		
Visual Disturbance			Rash		
Respiratory	**YES**	**NO**	Wound		
Chest Tightness			**Neurological**	**YES**	**NO**
Choking			Dizziness		
Cough			Headaches		
Shortness of Breath			Seizures		
Cardiovascular	**YES**	**NO**	Weakness		
Chest Pain			**Hematologic**	**YES**	**NO**
Leg Swelling			Swollen Lymph Nodes		
Palpitations			Bruises/bleeds easily		
Gastrointestinal	**YES**	**NO**	**Psychiatric**	**YES**	**NO**
Abdominal Pain			Confusion		
Blood in Stool			Decreased Concentration		
Diarrhea			Sleep Disturbance		
Nausea					
Vomiting					

UAB MEDICINE
MULTISPECIALTY CLINIC
BAPTIST MEDICAL CENTER SOUTH

2119 East South Boulevard
Montgomery, AL 36116
(334) 613-7070

Patient Name: ________________________________ Date of Birth: __________________________

AUA Symptom Score (For both Men and Women)

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Nocturia Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	None	1 time	2 times	3 times	4 times	5 times

Add up your scores for the AUA total score: ___________

(0-7 mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic)

Quality of life due to urinary symptoms: (please circle the number corresponding to your answer) *If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?*

PGI-S:

1 – Delighted

2 – Pleased

3 – Mostly satisfied

4 – Mixed

5 – Mostly dissatisfied

6 – Unhappy

7 – Terrible

Circle the one number that best describes how your urinary tract condition is now:

1 – Normal *2 – Mild* *3 – Moderate* *4 - Severe*