NEW PATIENT FORM

Thank you for booking your appointment with Sydney Urology Care. Please complete the form below and either email it to our office at info@sydneyurologycare.com or print and bring it along with you to your appointment.

Your Details		
Title	Surname	First Name
Address:		Telephone
Date of Birth / /	Age	Gender M/F
Country of Birth	Occupation	
Next of Kin		Telephone:
Email Address		
Marital Status		
Local General Practitioner		
Private Hospital Cover Yes /. No (circle) Fund: Membership No: _____ Did you join the fund less than 12 months ago or have you made any changes to your level of cover? If so, please indicate: Newly joined or updated (circle)		
Department of Veteran's Affairs Pens No. Gold/White		
Medicare Number _ _ _ _ _ _ _ _ _ _ _ Expiry Date ___/___ Patient No ____		
Are you a diabetic? Yes/No (circle)		
Are you allergic to any medications Yes/No (circle)		

Do you smoke? Yes/No/ Given Up – when? (circle)
How much alcohol do you drink?
Past illnesses – please detail:
Past operations – please detail:
What medications are you on currently? Include over the counter medication/vitamins

Today's Concerns – Why are you here today?		
☐ Recurrent urinary infection	☐ Blood in urine	☐ Poor bladder control (leakage)
☐ Frequency/Urgency	☐ Kidney stones	☐ Prostate check/PSA
☐ Difficulty emptying bladder	☐ Pain/burning when urinating	☐ Prostate cancer
☐ Getting up at night	☐ Other	

How frequently do you pass urine during the day? ☐ Every 4-6 hours ☐ 3-4 hours ☐ 2-3 hours ☐ 1- 2 hours ☐ every hour ☐ more often
How often do you have to get up at night to pass urine? ☐ none ☐ once ☐ twice ☐ 3-4 times ☐ more often

When you pass urine, what is the flow like? ☐ good stream ☐ fair stream ☐ poor stream ☐ varies a lot

1. Delay in starting? ☐ Yes ☐ No
2. Stops and starts? ☐ Yes ☐ No
3. Dribbles afterwards? ☐ Yes ☐ No

Do you feel that you get your bladder empty when you pass urine?

☐ Yes ☐ No ☐ Doesn't empty ☐ Do not know

Any sexual problems? ☐ Yes ☐ No. Specify

Do you have to go to the toilet urgently when you want to go? ☐ Yes ☐ No

Why is it urgent? Pain or discomfort ☐ Yes ☐ No Fear of leakage? ☐ Yes ☐ No

Do you leak on the way to the toilet if you can't get there in time? ☐ Yes ☐ No

Do you ever leak when you cough or sneeze or lift something? ☐ Yes ☐ No

Have you ever had a

1. Bladder infection? ☐ Yes ☐ No
2. Kidney infection? ☐ Yes ☐ No
3. Prostate infection? ☐ Yes ☐ No
4. Sexual transmitted disease? ☐ Yes ☐ No

Do you have any of the following conditions?

1. High Blood Pressure? ☐ Yes ☐ No
2. Heart disease/heart valve abnormality/angina? ☐ Yes ☐ No
3. Asthma/Bronchitis/lung problems? ☐ Yes ☐ No
4. Diabetes? ☐ Yes ☐ No
5. Bowel disease? ☐ Yes ☐ No
6. Problems with the nervous system/spinal cord / MS? ☐ Yes ☐ No
7. Bruise easily or bleed? ☐ Yes ☐ No

Have you ever had problems with anesthetic? ☐ Yes ☐ No
Are you under the care of any other doctor, other than the one referring you? ☐ Yes ☐ No If yes, please specify:
When and where did you have your last imaging (e.g. x-ray, CT, MRI)? Please bring in all imaging results to your appointment

The Privacy Act (1998) requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's information. This practice will collect information that is necessary to properly advise and treat you. With your consent, this practice will use and disclose your information for purposes such as referral to other health care providers/hospitals, obtaining advice on treatment options, billing, medical defence insurance notification obligations or where legally required to produce records. You are entitled to access your files upon request. If you require further information, please discuss this during your consultation.

I consent to my clinical notes and de-identified images (x-rays, scans) being used for research, training or educational purposes.
Please sign once you have read the above.

Signature: _____. Date: _____