Arizona Focal Prostate Center
6369 E. Tanque Verde Rd. Suite 160 Tucson, AZ 85715
New Patient Paperwork
**** Please fill out form completely ****

Date: _____/_____/_____ **How did you learn about our office?** _____

Patient's Last Name: _____ First: _____ MI: _____

Sex: ❑ Male ❑ Female Date of Birth: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____Work Phone: (_____) _____

Social Security Number: _____-_____-_____Email Address: _____
(Social required per your insurance)

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner ❑ Legal Separated

Spouse/Parent/Guardian Name: _____Relationship: _____

Spouse/Parent/Guardian Phone Number: (_____) _____Email Address: _____

Emergency Contact: _____ Relationship: _____Phone:(_____) _____

Patient's Employer: _____ Occupation: _____

Current work Status: ❑ Regular ❑ Light duty - (how long? _____) ❑ Disabled ❑ Retired
❑ Student ❑ Not working due to this problem

Primary Care Doctor Name: _____Phone: (_____) _____

Pharmacy Preference (include location) _____Phone:(_____) _____

Primary Insurance Information:

Insurance Name: _____ ID Number: _____ Group: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Insured: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

Policyholder/Subscriber: _____DOB: _____/_____/_____Social Security: _____-_____-_____

Secondary Insurance Information:

Insurance Name: _____ ID Number: _____ Group: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Insured: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

Policyholder/Subscriber: _____DOB: _____/_____/_____Social Security: _____-_____-_____

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What is the reason for your visit? _____

How long has the problem bothered you? _____

Previous Physicians seen for this problem? ❑No ❑Yes, if yes give information below.

Physician Name: _____ Phone: (_____) _____

Specialty: _____ Date Seen: _____/_____/_____

Treatments: _____ Reason for Leaving: _____

When was your last physical exam? _____

Did you have: EKG _____ Chest X-Ray _____ Results _____

Imaging Done? (CT, MRI, X-Ray) Date: _____/_____/_____ Location: _____

Labs? Date: _____/_____/_____ Location: _____

What medications are you currently taking (include over-the-counter and herbal supplements)?

_____ _____ _____

_____ _____ _____

_____ _____ ❑ **I take no medications**

Are you allergic to any medications, tape, iodine, shellfish, or Latex? ❑ **No Allergies**
If "YES", list your allergies and the reaction.

Allergy: _____ Reaction: _____Date: _____/_____/_____

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Allergy: _____ Reaction: _____Date: _____/_____/_____

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Past Medical History:

❑Asthma/Emphysema	❑Kidney Disease	_____
❑Back injury/arthritis	❑Liver disease/hepatitus	_____
❑Diabetes	❑Psychiatric Disease	_____
❑High Cholesterol	❑Stomach ulcers	_____
❑High Blood Pressure/Hypertension	❑Strokes	_____
❑Heart attack (MI/Angina)	❑Tuberculosis	_____
❑Heart valve/heart rhythm problem	❑Cancer (type/date)	_____
❑Other _____		

Past Surgical History: (please check/list any surgeries you have had and the date) **❑No previous surgeries**

❑Prostate	_____	❑Other	_____
❑Hysterectomy	_____	❑Other	_____
❑Bladder	_____	❑Other	_____
❑Kidney stone	_____	❑Other	_____
❑Gallbladder	_____	❑Other	_____
❑Appendectomy	_____	❑Other	_____
❑Tonsillectomy	_____	❑Other	_____
❑Heart bypass/valve	_____	❑Other	_____

Hospitalizations (other than for surgery):

Date	Days Hospitalized	Reason for Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History (check all illnesses that run in your family):

❑Problems with anesthesia	❑Bleeding problems	❑Clotting disorder
❑Diabetes	❑High blood pressure	❑Heart attacks
❑Stroke	❑Vascular disease	❑Heart failure
❑Kidney stones	❑Prostate cancer	❑Kidney cancer

Are your parents deceased? ❑Yes ❑No **Cause** _____

Any other conditions the doctor should know about? ❑Yes ❑No _____

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Are you currently having, or have had problems with any of the following?:

	Yes	No	If **Yes**, please explain.
Arthritis/joints	❑	❑	_____
Blood circulation problems (clots, varicose)	❑	❑	_____
Complications from childhood disease	❑	❑	_____
Depression/anxiety	❑	❑	_____
Excessive bleeding / Easy bruising	❑	❑	_____
Eyes	❑	❑	_____
General Health (e.g., fever, weight loss)	❑	❑	_____
Heart	❑	❑	_____
Lungs	❑	❑	_____
Neurological	❑	❑	_____
Rheumatic or Scarlett Fever	❑	❑	_____
Seizure Disorder	❑	❑	_____
Serious infections	❑	❑	_____
Skin	❑	❑	_____
Stomach/bowel	❑	❑	_____
Thyroid Disease	❑	❑	_____
Traumatic injuries or broken bones	❑	❑	_____
Do you take antibiotics for dental work?	❑	❑	_____
Do you ever leak urine and when?	❑	❑	_____

Social History:

Occupation _____

Marital Status ❑ Single ❑ Married ❑ Domestic Partner ❑ Divorced

How much do you smoke? ❑ Never ❑ _____ pack/d for _____ yrs ❑ Former, quit _____ yrs ago

How much do you drink? ❑ Never ❑ Rarely ❑ Drinks per week _____

Do you use drugs? ❑ Never ❑ Drugs used _____

For Women:

Is there any chance you could be pregnant? ❑ Yes ❑ No

When was your last menstrual period? _____