

CONFIDENTIAL INFORMATION

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PATIENT INFORMATION

Social Security Number _____

Name _____ Birth date _____
First Mi Last

Address _____ City _____

State _____ Zip _____ Home Phone () _____

Patient's Or Parent's Employer _____ Work Phone () _____

Business Address _____ City/State _____ Zip _____

Spouse Or Parent's Name _____

Employer _____ Work Phone () _____

Address _____ City/State _____ Zip _____

Whom May We Thank For Referring You? _____

Person To Contact In Case Of An Emergency _____ Phone () _____

INSURANCE INFORMATION

Primary Ins _____ Primary Ins. Identification # _____

Secondary Ins _____ Second Id # _____ Union Or Local # _____

Primary Ins Addr _____ City/State _____ Zip _____

How Much Is Your Deductible _____ How Much Have You Used? _____ Max. Annual Benefit _____

METHOD OF PAYMENT: CASH: _____ CHECK: _____ CREDIT CARD: _____

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to _____ and understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE: X _____

Name _____ DOB _____ Date _____

CHIEF COMPLAINT: Please describe in **ONE SENTENCE** your main urological problem:

Please check any of the following you have.

- | | | | |
|--|--|--|--|
| Heart failure <input type="checkbox"/> | Heart Attack <input type="checkbox"/> | Stroke <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> |
| COPD/Emphysema <input type="checkbox"/> | Kidney disease <input type="checkbox"/> | Ulcer Disease <input type="checkbox"/> | Hepatitis <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Artificial Joints <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> |
| Artificial Heart Valves <input type="checkbox"/> | | | |

OTHER MEDICAL PROBLEMS:

1.	3.
2.	4.

PREVIOUS SURGERIES

DATES

PREVIOUS SURGERIES	DATES
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Have you seen a urologist before? Yes No

If yes, reason: _____

Any Family History of Urologic or Gynecologic Problems

Explain _____

Name _____ DOB _____

MEDICATIONS YOU TAKE

ALLERGIES

1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.

Social History/Habits:

Are you? Married Divorced Never married

Do you have children? Yes (how many? _____) No

I am: currently working as a _____

retired from work as a _____

unemployed

Have you ever used tobacco? Yes No If Yes, how much? _____

Do you currently smoke? Yes No If Yes, how much? _____ (packs per day)

Do you drink alcohol? Yes No How many drinks per day? _____

Have you ever had a transfusion? Yes No

Have you ever used recreational intravenous drugs? Yes No

Are you HIV+ or do you have AIDS? Yes No

Have you ever been exposed to industrial dyes or heavy pesticides? Yes No

Local Pharmacy: _____ Phone () _____

PATIENT NAME: _____ DOB _____

HISTORY & REVIEW OF SYSTEMS

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING? If yes, explain below.

<u>EYES:</u>	<u>YES</u>	<u>NO</u>	<u>EARS, NOSE,</u>	<u>YES</u>	<u>NO</u>
Decreased vision	<input type="checkbox"/>	<input type="checkbox"/>	<u>MOUTH & THROAT:</u>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
			Mouth pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>
<u>PULMONARY (LUNG):</u>	<u>YES</u>	<u>NO</u>	<u>CARDIAC (HEART):</u>	<u>YES</u>	<u>NO</u>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			
<u>GASTROINTESTINAL:</u>	<u>YES</u>	<u>NO</u>	<u>MUSCULAR/SKELETAL:</u>	<u>YES</u>	<u>NO</u>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Deceased appetite	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowels	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain or weakness	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>			
Liver/Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<u>NEUROLOGIC:</u>	<u>YES</u>	<u>NO</u>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy/Faint spells	<input type="checkbox"/>	<input type="checkbox"/>
			Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>
<u>ENDOCRINE:</u>	<u>YES</u>	<u>NO</u>	Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>			
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<u>PSYCHIATRIC:</u>	<u>YES</u>	<u>NO</u>
Thyroid Medication	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>
			Depression	<input type="checkbox"/>	<input type="checkbox"/>
<u>URINARY TRACT:</u>	<u>YES</u>	<u>NO</u>	Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>
Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>	<u>REPRODUCTIVE SYSTEM:</u>	<u>YES</u>	<u>NO</u>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bloody urine	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>
Sugar/Albumin urine	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>
Passing urine/night	<input type="checkbox"/>	<input type="checkbox"/>	Sexual impotence	<input type="checkbox"/>	<input type="checkbox"/>
Slow starting/urine	<input type="checkbox"/>	<input type="checkbox"/>			
Weak urine stream	<input type="checkbox"/>	<input type="checkbox"/>	<u>ALLERGIES:</u>	<u>YES</u>	<u>NO</u>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	To Dust	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disease	<input type="checkbox"/>	<input type="checkbox"/>	To Plants	<input type="checkbox"/>	<input type="checkbox"/>
Freq urine Infection	<input type="checkbox"/>	<input type="checkbox"/>	To Animals	<input type="checkbox"/>	<input type="checkbox"/>

EXPLANATION: _____
