

PATIENT HISTORY FORM

Date: _____

Note: This is a confidential record and will be kept in your doctors' office. Information contained here will not be released to anyone without your authorization to do so.

Last Name _____ First Name _____ MI _____

Age _____ Occupation _____ Primary Care Physician _____

Date of Birth _____ Martial Status _____

Can we give test results to a spouse of family member? _____

Name of spouse or family member(s) _____

CHIEF COMPLAINT (What is the main reason for your visit today?) _____

PAST MEDICAL HISTORY

HAVE YOU EVER SMOKED? Y N

How many years? _____

How many packs/day? _____

DO YOU SMOKE CURRENTLY? Y N

DO YOU DRINK? Y N

If yes, how much? _____

List any *personal* past illnesses and/or surgeries (with date)

List CURRENT MEDICATIONS USED with doses
(INCLUDE NON-PRESCRIPTION MED'S)

Family history of PROSTATE CANCER? Y N

Family history of KIDNEY STONES? Y N

Family history of KIDNEY DISEASE? Y N

List and serious illnesses in your *Immediate Family*
(eg.: diabetes, cancer, heart disease, tuberculosis)

Do you have medication allergies? Y N
Please list: _____

Name: _____

DOB: _____

UROLOGIC CONSULTANTS, PC
Barry E. Gordon, MD

REVIEW OF SYSTEMS

Do you now, or have you in the past, had any problems related to the following systems?
Circle **YES** or **NO** and *Date Occurrence*. If necessary, please explain any yes answers.

<p>Cardiovascular <i>No Problems</i> <input type="checkbox"/></p> <p>Chest pain/Angina Y N</p> <p>High Blood Pressure Y N</p> <p>Heart Attack Y N</p> <p>Irregular Heartbeat Y N</p> <p>Heart Failure Y N</p> <p>Pacemaker Y N</p> <p>Circulation Problems Y N</p>	<p>Genitourinary <i>No Problems</i> <input type="checkbox"/></p> <p>Painful Urination Y N</p> <p>Urinary Retention Y N</p> <p>Urinary Frequency Y N</p> <p>Blood in Urine Y N</p> <p>Nighttime Urination (# of times=) </p> <p>Infection of Bladder or Kidneys Y N</p> <p>Incomplete Bladder Emptying Y N</p> <p>Loss of Urine with Cough Y N</p> <p>Run to Urinate Y N</p>
<p>Constitutional Symptoms <i>No Problems</i> <input type="checkbox"/></p> <p>Fever Y N</p> <p>Chills Y N</p> <p>Headache Y N</p> <p>Unexplained Weight Loss Y N</p> <p>Other </p>	<p>Hematologic <i>No Problems</i> <input type="checkbox"/></p> <p>Blood Clotting Problems Y N</p> <p>Swollen Glands Y N</p> <p>AIDS/HIV Y N</p> <p>Anemia Y N</p> <p>Other </p>
<p>Respiratory <i>No Problems</i> <input type="checkbox"/></p> <p>Shortness of Breath Y N</p> <p>Frequent Cough Y N</p> <p>Wheezing Y N</p>	<p>Eyes <i>No Problems</i> <input type="checkbox"/></p> <p>Blurred Vision Y N</p> <p>Double Vision Y N</p> <p>Other </p>
<p>Gastrointestinal <i>No Problems</i> <input type="checkbox"/></p> <p>Abdominal Pain Y N</p> <p>Nausea/Vomiting Y N</p> <p>Heartburn Y N</p> <p>Constipation Y N</p> <p>Diarrhea Y N</p>	<p>Neurologic <i>No Problems</i> <input type="checkbox"/></p> <p>Forgetfulness/Confusion Y N</p> <p>Fainting/Dizzy Spells Y N</p> <p>Numbness/Tingling Y N</p> <p>Mental Health Problems Y N</p> <p>Stroke/TIA Y N</p>
<p>Musculoskeletal <i>No Problems</i> <input type="checkbox"/></p> <p>Joint Pain Y N</p> <p>Neck/Back Pain Y N</p> <p>Muscle Weakness Y N</p> <p>Arthritis Y N</p> <p>Osteoporosis Y N</p>	<p>Allergic/Immunologic <i>No Problems</i> <input type="checkbox"/></p> <p>Hay Fever Y N</p> <p>Drug Allergies Y N</p> <p>Other </p>
<p>Miscellaneous <i>No Problems</i> <input type="checkbox"/></p> <p>Diabetes Y N</p> <p>Thyroid Problems Y N</p> <p>Chemo/Radiation Y N</p>	<p>Psychologic <i>No Problems</i> <input type="checkbox"/></p> <p>Are you generally satisfied with your life? Y N</p> <p>Do you feel severely depressed? Y N</p> <p>Have you considered suicide? Y N</p>

*Urologic Consultants, PC
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ASSIGNMENT OF INSURANCE BENEFITS

I hereby give authorization for payment of insurance benefits to be made directly to UROLOGIC CONSULTANTS, PC for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize my healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I will also pay any bank fees for returned checks.

SIGNATURE _____ DATE _____

PATIENT DEMOGRAPHICS INFORMATION
(Please Print)

SS#: _____ - _____ - _____ PATIENT'S NAME: _____
Last Name First Name Middle Initial

PERMANENT ADDRESS: _____ APT#: _____
CITY: _____ STATE: _____ ZIP: _____

LOCAL ADDRESS: _____ APT#: _____
CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: ____/____/____ SEX: (M/F) MARITAL STATUS: (S/M/W/D)
Month Day Year

PHONE #: (____) ____-____ WORK #: (____) ____-____ OTHER PHONE #: (____) ____-____

PRIMARY CARE PHYSICIAN: _____ PCP PHONE: (____) ____-____

PATIENT EMPLOYER: _____

Primary Insurance

Ins. Co. Name: _____
Policy #: _____ Group #: _____
Insured's Name: _____
Relation to Patient: _____
Insured's Date of Birth: _____ M/F
Insured's Employer: _____
Insured's SS#: _____

Secondary Insurance

Ins. Co. Name: _____
Policy #: _____ Group #: _____
Insured's Name: _____
Relation to Patient: _____
Insured's Date of Birth: _____ M/F
Insured's Employer: _____
Insured's SS#: _____

Who may receive information regarding your Protected Health Information? (Check ALL that apply)

Spouse ____ Name: _____ Date of Birth: ____/____/____

Children ____ Name: _____ Date of Birth: ____/____/____
Name: _____ Date of Birth: ____/____/____
Name: _____ Date of Birth: ____/____/____
Name: _____ Date of Birth: ____/____/____

Parent/ Guardian ____ Name: _____ Date of Birth: ____/____/____

Significant Other/Friend ____ Name: _____ Date of Birth: ____/____/____
Name: _____ Date of Birth: ____/____/____

May we leave a message regarding test results and appointments on your answering machine? _____ Yes _____ No

I have received a copy of the Privacy Rules from this provider and authorized the above person(s) who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Date: _____ Signature: _____

Circle One (PATIENT/ PARENT/ GUARDIAN)

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE TO YOU.