

**(Please Fill Out Completely)**

Date: \_\_\_\_\_ Home Phone # \_\_\_\_\_  
 Cell Phone # \_\_\_\_\_  
 Work Phone # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: M S D W Sex: Male Female

Patient Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Patient SS # \_\_\_\_\_ Drivers License # \_\_\_\_\_ e-mail: \_\_\_\_\_

Patient Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse Name \_\_\_\_\_ Ok to release Medical Information spouse?  YES  NO

Spouse Employer or School if Child \_\_\_\_\_ Job Title \_\_\_\_\_ Phone \_\_\_\_\_  
\*Applies only to parents of minor children or children insured under the parents insurance

\*Parent Name: \_\_\_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_  
 \*Parent Name: \_\_\_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Primary Care Doctor \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name / Location \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

<b>Primary Insurance</b>		<b>Name of Insured</b>	
Insurance Address _____	_____	Policy # _____	Group # _____
Date of Birth of Insured _____	SS# of Insured _____		
Customer Service Phone Number _____			
<b>Secondary Insurance</b>		<b>Name of Insured</b>	
Insurance Address _____	_____	Policy # _____	Group # _____
Date of Birth of Insured _____	SS# of Insured _____		
Customer Service Phone Number _____			

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 I certify that I am the patient or duly authorized general agent of the patient and am authorized to complete this information request. I authorize the release of any medical information necessary to process claims for services rendered. I also authorize payment of medical benefits on claims filed by this office to **Urology Specialists**.

**\*PAYMENT IS EXPECTED AT TIME OF SERVICE, WE ACCEPT CHECK, CASH, VISA, MATERCARD, AMERICAN EXPRESS AND DISCOVER\***

**Signature of Patient**  
 X \_\_\_\_\_

**Signature of Responsible Party**  
 X \_\_\_\_\_



Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

REASON FOR YOUR VISIT TODAY: \_\_\_\_\_

Have you or do you have any of the following: Check / Circle all that applies to you

<input type="checkbox"/> Diabetes Date Diagnosed: _____ <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Lung Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Clots in legs <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Hernia <input type="checkbox"/> Hearing loss <input type="checkbox"/> Heart attack <input type="checkbox"/> Aneurysm	<input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Emphysema / Bronchitis <input type="checkbox"/> Hepatitis A B Or C <input type="checkbox"/> Urinary Infections <input type="checkbox"/> Prostatitis <input type="checkbox"/> Kidney disease <input type="checkbox"/> Glaucoma Open or Closed <input type="checkbox"/> Depression <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Stroke <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Liver disease
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Previous Surgery / Hospitalization (LIST ALL) \_\_\_\_\_

Medications: (INCLUDE OVER THE COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS) \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

FEMALE PATIENTS ONLY

Are you or could you be pregnant? Yes / No # of pregnancies: \_\_\_\_\_  
Date of Last Menstrual Period: \_\_\_\_\_ Type of Birth Control \_\_\_\_\_

FAMILY HISTORY

Do any of the following medical problems run in your family?

- |  |  |
|--|--|
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Cancer Type: _____  |
| <input type="checkbox"/> Stroke          |  |

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY**

Exercise: Yes / No    Alcohol: Yes / No    Amount: \_\_\_\_\_    Caffeine: Amount per day \_\_\_\_\_

Tobacco Usage    Yes / No    # of Years \_\_\_\_\_, Quit \_\_\_\_\_

Employment: \_\_\_\_\_    Occupation: \_\_\_\_\_

**UROLOGICAL HISTORY:**  
(PLEASE CHECK ALL THAT APPLY)

Urological Surgeries / Problems, Please List \_\_\_\_\_  
\_\_\_\_\_

- Any pain or burning when voiding / urinating?
- Any urgency or need to run to the bathroom?
- Any Urinary frequency or need to void many times during the night?
- Any sense of incomplete emptying of your bladder?
- Any leakage of urine?
- Any blood in urine?
- Any pain? If yes, where is your pain located? \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE

(FOR PHYSICIAN USE ONLY)

VITALS:    T    BP    P    R    WT



Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT YOU CURRENTLY HAVE**

**CONSTITUTIONAL**

- FEVER
- CHILLS
- WEIGHT CHANGE

**EYES**

- BLINDNESS
- DOUBLE VISION
- BLURRED VISION
- BURNING
- GLAUCOMA OPEN / CLOSED

**EAR, NOSE, THROAT**

- RINGING IN THE EARS
- HEARING LOSS
- HEARSENESS
- SORE THROAT
- RECURRENT NOSE BLEEDS
- MOUTH ULCERS
- EAR INFECTION

**CARDIOVASCULAR**

- CHEST PAIN
- PALPITATIONS
- IRREGULAR HEART BEAT
- ANKLE SWELLING
- HEART FAILURE

**MUSCULOSKELETAL**

- MULTIPLE JOINT SELLING
- GOUT
- MULTIPLE FRACTURE
- NIGHT CRAMPS
- NECK PAIN
- BACK PAIN

**RESPIRATORY**

- COUGH
- SHORTNESS OF BREATH
- COUGH WITH BLOOD
- WHEEZING

**URINARY**

- PAINFUL URINATION
- URINARY FREQUENCY
- BLOOD IN URINE
- LOSS OF BLADDER CONTROL
- URINARY DISCHARGE

**GASTROINTESTINAL**

- ABDOMINAL PAIN
- DIARRHEA
- NAUSEA / VOMITING
- CONSTIPATION
- INDIGESTION / HEARTBURN
- BLOATING

**IMMUNOLOGICAL**

- FOOD SENSITIVITY
- ASTHMA
- RECENT VACCINATIONS

**ENDOCRINE**

- HEAT / COLD INTOLERANCE
- INCREASED THIRST
- FREQUENT URINATION
- HAIR LOSS
- TIRED / SLUGGISH

**HEMATOLOGIC**

- SPONTANEOUS BLEEDING
- BRUISING
- ENLARGED LYMPH NODES
- ANEMIA
- JAUNDICE

**NEUROLOGICAL**

- TREMORS
- DIZZINESS
- HEADACHES
- SEIZURES
- NUMBNESS / TINGLING

**PSYCHOLOGICAL**

ARE YOU GENERALLY SATISFIED WITH YOUR LIFE?  
 YES  NO

DO YOU FEEL SEVERLY DEPRESSED?  
 YES  NO

HAVE YOU EVER CONSIDERED SUICIDE?  
 YES  NO