PLEASE PRINT AND FILL OUT COMPLETELY

NAME: LAST FIRST MI

PRIMARY CARE PHYSICIAN

____ M F
AGE SEX DATE OF BIRTH SOCIAL SECURITY NUMBER

REFERRED BY: DOCTOR, OTHER

ADDRESS: STREET APT# CITY STATE ZIP

HOME PHONE CELL PHONE

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ WORK PHONE: _____

MARITAL STATUS: S M W D SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ HOME PHONE: _____

RELATIONSHIP: _____ WORK PHONE: _____

(RESPONSIBLE PARTY INFORMATION IF DIFFERENT THAN ABOVE)

NAME SOCIAL SECURITY NUMBER DATE OF BIRTH

RELATIONSHIP TO PATIENT: _____ HOME PHONE: _____

ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ WORK PHONE: _____

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME: _____	INSURANCE NAME: _____
POLICYHOLDER: _____	POLICYHOLDER: _____
ID #: _____	ID #: _____
GROUP #: _____	GROUP #: _____

AUTHORIZATION TO RELEASE INFORMATION:
I HEREBY AUTHORIZE *SOUTHWEST UROLOGY ASSOCIATES, P.C.* TO FURNISH INFORMATION TO MY PRIMARY/REFERRING PHYSICIAN AND/OR TO INSURANCE CARRIERS CONCERNING MY DIAGNOSIS AND TREATMENTS, INCLUDING MY HIV STATUS.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS AND AGREEMENT TO PAY:
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO *SOUTHWEST UROLOGY ASSOCIATES, P.C.* FOR THE SERVICES RENDERED BY THEM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTORS FOR CHARGES NOT COVERED BY THIS AUTHORIZATION. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE AND THAT IT IS CUTOMARY TO PAY FOR ALL SERVICES WHEN RENDERED, UNLESS ARRANGEMENTS ARE MADE IN ADVANCE.

SIGNATURE: _____ DATE: _____

PAST MEDICAL HISTORY

Patient name: _____ Date: _____

Height: Weight:

SOCIAL HISTORY:
HOW MUCH PER DAY DO YOU USE THE FOLOWING?
Tobacco _____ Alcohol _____ Coffee/Tea _____
Do you have a history of tobacco use? Number of years Packs per day Date Stopped

DIETS:
ARE YOU ON ANY SPECIAL DIETS? _____

Your FAMILY HISTORY:
HAVE ANY OF **YOUR BLOOD RELATIVES** EVER HAD ANY OF THE FOLLOWING?

_____Bladder Cancer	_____Tuberculosis	_____Stroke	_____Gout
_____Prostate Cancer	_____Heart Disease	_____Bleeding Disorder	_____Diabetes
_____Testicular Cancer	_____Heart Attack	_____High Blood Pressure	

_____Other Cancer (Describe): _____

MEDICATION:
LIST ALL MEDICATION YOU ARE PRESENTLY TAKING: _____NONE?

Name	Dosage (mg)	Times per day
Herbs/Homeopathic Meds:		

PHARMACY NAME: _____ PHONE: _____

ALLERGIES:
LIST ALL DRUG ALLERGIES: _____NONE?

_____

_____

LIST ALL **HOSPITALIZATIONS AND SURGERIES:**
(include childhood hospitalizations and surgeries)

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

LIST ANY OTHER **MEDICAL ILLNESSES** (and how long you have had them):
Illness: _____ How Long? _____
Illness: _____ How Long? _____
Illness: _____ How Long? _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING CANCER? YES NO

If yes, what type? _____

PATIENT HISTORY FORM

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

Patient name: _____ **Date:** _____

Chief Complaint: What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

_____

_____

History of Present Illness

Please answer the following questions.

When did you first notice the problem?
Explain:

Location of the problem:
Abdomen Back Leg
Other:

Is the problem constant or variable? Sharp or Dull?
Explain:

On a scale of 1 to 10, with 10 being the most severe, circle the number that best describes the severity of your problem.

1 2 3 4 5 6 7 8 9 10

How long does the problem last?
30 minutes 1 hour It is always there
Comes and goes Other:

Is there anything occurring at the same time?
Yes **No** If yes, explain:

Does anything make the problem worse?
Explain:

Does the problem interfere with your normal daily functions?
Yes **No** If yes, explain:

Urinalysis
Leuk-
Nitrites-
Urobili-
Protein-
pH-
Blood-
SG-
Ket-
Bili-
Gluc-

Micro
WBC-
RBC-
Bact-
Crystal-
Phos-
Epi's-
Mucous-

Physician use only: (Comments/Notes)

UROLOGIC HISTORY

PATIENT NAME: _____ DATE: _____

Please circle **Y** for Yes and **N** for No for the following questions.

1. Have you ever had a bladder infection? **Y** **N** If yes, when? _____
2. Have you ever had a kidney infection? **Y** **N** If yes, when? _____
3. Have you ever had a prostate infection? **Y** **N** If yes, when? _____
4. Have you ever been told you have blood in your urine? **Y** **N** If yes, when? _____
5. Have YOU ever SEEN blood in YOUR urine? **Y** **N** If yes, when? _____
6. Have you ever had kidney stones? **Y** **N** If yes, when and which side? _____
7. Are you having pain or discomfort when you urinate? **Y** **N**
8. How many times during the daytime do you urinate? _____

For questions 9 through 14 use this scale Choose the number that best describes the frequency that you experience these conditions.	0 Not at all	1 Less than 20% of the time	2 Between 20-50% of the time	3 About 50% of the time	4 Between 51-90% of the time	5 Over 90% of the time
9. Over the past month or so, how often have you had the sensation of not emptying your bladder?	**0**	**1**	**2**	**3**	**4**	**5**
10. Over the past month or so, how often have you had to urinate again less than 2 hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
11. Over the past month or so, how often have you found that you stopped and started several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
12. Over the past month or so, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
13. Over the past month or so, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
14. Over the past month or so, how often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**

15. Over the past month so, how many times per night did you get up to urinate?
____None ____1 Time ____2 Times ____3 Times ____4 Times ____5 times or more

Quality of life due to Urinary Symptoms	Delighted	Pleased	Mostly satisfied	Mixed-About equally satisfied and dissatisfied	Unhappy	Terrible
16. If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?						

REVIEW OF SYSTEMS

Name: _____ **Date:** _____

Do you now or have you had any of the following problems? Circle Y for Yes or N for No.

Please explain any Yes answers in the space provided.

GENERAL:		
Weight loss	Y	N
Recent fever	Y	N
ENDOCRINE:		
Thyroid trouble	Y	N
Diabetes	Y	N
RESPIRATORY:		
Asthma	Y	N
Recent coughing	Y	N
Recent coughing up	Y	N
Phlegm	Y	N
Coughing blood	Y	N
Shortness of breath	Y	N
CARDIOVASCULAR:		
High blood pressure	Y	N
Heart attack	Y	N
Heart murmur	Y	N
Rheumatic fever	Y	N
Ankle swelling	Y	N
Chest pains	Y	N
Heart palpitations	Y	N
Leg muscle pain when walking	Y	N
NEUROLOGICAL:		
Convulsions	Y	N
Stroke	Y	N
Paralysis	Y	N
Seizures	Y	N
Head injuries	Y	N
Back injuries	Y	N
Back surgery	Y	N
FEMALE GENITAL:		
Menstrual problems	Y	N
Vaginal discharge	Y	N
Breast lump	Y	N
MUSCULOSKELETAL:		
Arthritis	Y	N
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

GASTROINTESTINAL:		
Recent indigestion	Y	N
Recent heartburn	Y	N
Abdominal pain	Y	N
Recent nausea	Y	N
Recent vomiting	Y	N
Gall stones	Y	N
Ulcer	Y	N
Severe constipation	Y	N
Recent diarrhea	Y	N
Bloody stools	Y	N
Black stools	Y	N
Hemorrhoids	Y	N
Hepatitis	Y	N
Jaundice	Y	N
HEMATOLOGICAL:		
Anemia	Y	N
Bleeding problems	Y	N
Blood clots	Y	N
Gout	Y	N
DERMATOLOGICAL:		
Recent rash	Y	N
Recent itching	Y	N
UROLOGICAL:		
Kidney stones	Y	N
Bloody urine	Y	N
Bladder infections	Y	N
Kidney infections	Y	N
Burning during urination	Y	N
Frequent urination	Y	N
Urine retention	Y	N
PSYCHOLOGICAL:		
Satisfied with life	Y	N
Depression	Y	N
Considered suicide	Y	N
OTHER:		
Sexual problems	Y	N
Tired	Y	N
Nervousness	Y	N
Venereal disease	Y	N

FINANCIAL PAYMENT POLICY

REGARDING INSURANCE: The doctor's service is provided directly to you and you are responsible for payment of these services. We cannot provide service on the assumption that charges will be paid by your insurance company. If we are not participating providers with your insurance company, we require payment be made at the time services are rendered. As a courtesy to our patients we will submit a paid claim to your insurance company for you.

Our office participates with Medicare and many managed care insurance companies. Should your insurance coverage be with one or more of these companies, we will bill your insurance company based on the guidelines of our contract. Co-payments and deductibles that have not been satisfied are required at the time services are rendered. It is your responsibility to obtain a proper referral from your primary care physician, if required by your insurance plan. Charges may be your responsibility if you do not secure a proper referral for the services provided.

If a surgical procedure is performed, our office will bill your insurance company directly and withhold any action for forty-five days. However, if your insurance company has failed to pay within forty-five days, we will expect you to pay the full balance due and then collect from your insurance company.

Informing our patients about our financial policy assists us in providing the best services to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please contact our billing staff or manager.

WE ARE HERE TO HELP YOU!

I hereby understand the financial policy of this office:

_____ _____

Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print)_____have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date