



Male Medical History Summary

Today's Date: ____/____/____

Name: _____ DOB: _____ Age: _____ Marital Status: _____

Height: _____ Weight _____ Please list your current Pharmacy: _____ Location: _____

Primary Care Doctor: _____ Location: _____

Please circle your current Lab your insurance requires you to use: Quest Lab Corp Peterson Lab NA

Reason for your visit/Chief Complaint: _____

Do you have any burning when you urinate? () YES () NO
Have you ever seen blood in your urine? () YES () NO

Have you ever been treated for:

Urinary infections? () YES () NO
Prostatitis? () YES () NO
Epididymitis? () YES () NO
Sexually transmitted diseases? () YES () NO

Answer the following questions based on your experience during the last month. (Please check box)

Table with 7 rows of questions and 6 columns of frequency options: Not at all, Less than 1/5 time, Less than half time, About half time, More than half time, Almost always.

Quality of Life

How would you feel if you were to spend the rest of your life with your urinary condition just the way it is now? (Circle one) Delighted Pleased Satisfied Most Satisfied Equally Satisfied & Dissatisfied Mostly Dissatisfied Unhappy Terrible

Current Medication names, dosage, & how often do you take your medication, also any over the counter medications

Three horizontal lines for writing medication names, dosages, and frequencies.

Name: _____ DOB: _____

Personal History:

Do you smoke?

How long?

How many a day?

When did you quit?

Do you Drink alcohol?

Amount in a week:

Amount of soda in a week?

Amount of coffee in a week?

Family Medical History (parents, grandparents, and sibling only)

Cancer:

Kidney/Bladder problems:

Diabetes:

Heart Disease:

Anesthesia problems:

Your medical illnesses: (examples – diabetes, high blood pressure....)

Allergies: (food, medication, and seasonal)

Have you been treated for MRSA Yes or No If yes, MRSA site _____ last culture _____

Do you have a LATEX allergy? Yes or No Do you have an allergy to shellfish? Yes or No

Surgeries: (type and date)

Do you have any Anesthesia Problems? Yes or No

In the last month have you had any of these symptoms: (Check yes or no)

Head and Neck:	Y() N() Headaches Y() N() Dizziness Y() N() Glaucoma	Neuro:	Y() N() Seizures Y() N() Numbness Y() N() Anxiety
Heart:	Y() N() Chest pain Y() N() Palpitations Y() N() Syncope (fainting)	Endocrine:	Y() N() Thyroid problems Y() N() Excessive thirst Y() N() Diabetes
Lungs:	Y() N() SOB(shortness of breath) Y() N() Cough Y() N() Productive sputum	Psychosocial:	Y() N() Depression or anxiety Y() N() Recent stressors Y() N() Change in lifestyle
GI:	Y() N() Abdominal pain Y() N() Constipation Y() N() Diarrhea	Heme/Lymph:	Y() N() Bleeding problems Y() N() Easy bruising Y() N() Sickle cell
GU:	Y() N() Frequency Urgency Y() N() Incontinence Y() N() Stones	General:	Y() N() Fatigue Y() N() Weight gain Y() N() Weight loss Y() N() Fever, chills



Associated Urologists, P.A.

PLEASE PRINT

PATIENT INFORMATION FORM

Today's Date: ____/____/____

Name: _____ Social Security # _____
 Home Address: _____ Home Phone: (____) _____ - _____
 City _____ State _____ Zip _____ Cell Phone: (____) _____ - _____
 Email Address: _____
 Sex: M F Age: _____ Birthdate _____ Single _____ Married _____ Widowed _____ Divorced _____

Please circle which apply: Ethnicity: Hispanic /Latino Non Hispanic /Non Latino

Language: Dutch English French Japanese Spanish

Race: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Other Pacific Islander White

Employed By: _____ Occupation: _____
 Employment Address: _____ Business Phone: (____) _____ - _____
 Referred By: _____ Are you seeing us due to an injury? _____
 Primary Medical Doctor: _____

FRIEND OR RELATIVE TO CALL IN CASE OF AN EMERGENCY

Name: _____ Phone: (____) _____ - _____
 Relationship: _____

INSURANCE INFORMATION

Person Responsible for Account _____ Social Security Number _____
 Relationship to Patient _____ Responsible Person Birthdate _____
 Address (if different from patient's) _____ Phone _____
 City _____ State _____ Zip _____

Primary Insurance _____ Identification Number: _____
 Group Number: _____ Policyholder Name: _____ DOB: _____

Secondary Insurance _____ Identification Number: _____
 Group Number: _____ Policyholder Name: _____ DOB: _____

Tertiary Insurance _____ Identification Number: _____
 Group Number: _____ Policyholder Name: _____ DOB: _____

Please circle the Lab your insurance requires: Irwin Quest Lab Corp Peterson Lab

I, the undersigned, hereby authorize **Associated Urologists** to **Discuss** or **Disclose** a report of my medical condition to:

Name: _____ Relationship: _____
 Name: _____ Relationship: _____
 Name: _____ Relationship: _____
 Name: _____ Relationship: _____

(spouse, family member, caregiver, friend, durable power of attorney) and to release my medical records to any referring or consulting physicians.

Signed: _____ Date: ____/____/____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ (Name of Insurance Company(ies))

and assign directly to **Associated Urologists, PA** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Signed: _____ Relationship to Patient: _____
 Date: ____/____/____

I hereby authorize medical information can be relayed to me via:

_____ Home Phone/Answering Machine Phone _____

_____ Work Phone or Voice Messaging System Phone _____

_____ Cell Phone/Answering Machine Phone _____

Signature of Patient/Patient Representative

Date

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received a copy of the Provider's

Notice of Privacy Practices for Protected Health Information
Effective Date: January 1, 2003
and revised February 04, 2011

Print Patient Name

Signature of Patient/Patient Representative

Date

Relationship to Patient