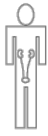


Female Medical History Summary

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
How often do you urinate? ___30 minutes	___1-2 hrs ___3-4 hrs	___5-6 hrs. ___ other
Do you have a constant urge to urinate?	( ) YES	( ) NO
How many times do you get up at night to urinate?	__________________	
Do you ever leak urine?	( ) YES	( ) NO
With cough, urge of both?	( ) YES	( ) NO
Number of pads:	__________________	
Do you have the inability to interrupt the stream?	( ) YES	( ) NO
Feelings of incomplete emptying?	( ) YES	( ) NO
Have you been treated for urinary infections?	( ) YES	( ) NO
Do you have back pain?	( ) YES	( ) NO
If yes, which side?	__________________	

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

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

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?

Obstetric History: Number of Pregnancies__________ Number of Deliveries__________

Number of Children
Vaginal delivery or C-section:
Long labor:
Largest baby:
Last pap:
Last mammogram:
Menopause:
Form of birth control:

Name: ________________________________ DOB: ___________

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)

____________________________ ____________________________ ____________________________

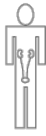
____________________________ ____________________________ ____________________________

___________________________ ____________________________ ____________________________

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