TEXAS UROLOGY SPECIALISTS

**Michael Wierschem, M.D. • Huong Hegde, M.D.**
**Mitchell Moskowitz, M.D. • Ted Klein, M.D.**

**(Please Fill Out Completely)**

Date _____

Home Phone #_____

Cell Phone # _____

Work Phone # _____

Email _____

Date of Birth _____ Age _____ Marital Status: M S D W Male Female

Last Name _____ First _____ Middle _____

Address: _____

City _____ State _____ ZIP _____

Patient Employer _____ Occupation _____

Spouse Name _____ Ok to release medical Information to spouse? Yes No

Emergency Contact _____ Phone _____

Pharmacy Name / Location _____ Phone _____

Primary Care Doctor _____ Phone _____

**Patient Name** _____ **Birth Date** _____

**Today's Date** _____

## MEDICATIONS

Do you take Ibuprofen, Aspirin, Coumadin, Plavix or other **blood thinners**? Yes No

Have you ever been told you needed antibiotics before a procedure? Yes No

Do you have any **drug allergies**? Yes No

If yes, please list below:

**DRUG:** **Type of Reaction:** (rash, nausea, etc)

Are you on any medication (include prescription, over the counter, and herbal supplements) Yes No

If yes, please list all below:

**DRUG:** **DOSE:** **HOW MANY TIMES A DAY:**

Have you ever been or are you now on any of the below medications?

| | | | | |
|---|---|---|---|---|
| Viagra / sildenafil | Levitra / vardenafil | Cialis / tadalafil | Proscar / finasteride | Avodart / dutasteride |
| Uroxatral / alfuzosin | Flomax / tamsulosin | Enablex / darifenacin | Ditropan / oxybutynin | Detrol / tolterodine |
| Vesicare / solifenacin | Cardura / doxazosin | Hytrin / terazosin | Sanctura / trospium chloride | |
| Testosterone | Coumadin / warfarin | Plavix / clopidogrel | Xarelto / rivaroxaban | |

**Patient Name** _____ **Birth Date** _____

**Today's Date** _____

## UROLOGICAL HISTORY

What is the reason for your visit? _____

Who referred you for this condition? (Doctor & Clinic) _____

When did this start? _____ Is this the first time you are being seen for this? _____

Do you experience any pain with urination? Y N Are you having any difficulty with urination? Y N

Do you experience any leakage of urine? Y N Have you ever had kidney stones? Y N

Do you have blood in your urine? Y N Are you experiencing any problems with erections? Y N

## SOCIAL HISTORY

Do you or did you ever smoke? Yes No
If yes, how many packs per day? _____ How many years? _____
Did you quit? Yes No If yes, when? _____

Have you or do you use now: Marijuana, cocaine, anabolic steroids, or heroin?

Do you exercise? Yes No
If yes, how much and how often: _____

Do you drink alcohol? Yes No
If yes, how much and how often: _____

Do you drink caffeine? Yes No Amount per day _____

Did you or do you ever work around chemicals? Yes No

If yes, please list: _____

For Females: Are you or could you be pregnant? Yes No

**Patient Name** _____ **Birth Date** _____

**Today's Date** _____

# PAST MEDICAL HISTORY

Have you ever had or been treated for any of the following conditions? Yes No

( ) High cholesterol
( ) High blood pressure
( ) Tuberculosis
( ) Glaucoma
( ) Gastroesophageal reflux
( ) Heart attack
( ) Herpes
( ) Heart disease
( ) Mitral Valve prolapse
( ) Diabetes
( ) Gout
( ) Prostatitis
( ) Kidney Infection
( ) Sexually transmitted disease
( ) Mumps
( ) Asthma
( ) Cancer: _____
( ) Depression
( ) Blood clot
( ) COPD
( ) HIV

Other:_____

Have you ever had any surgery? No Yes (If yes, please check or write down any surgeries and when)

( ) Colon _____
( ) Hysterectomy _____
( ) Angioplasty _____
( ) Inguinal Hernia _____
( ) Knee replacement _____
( ) Back _____
( ) Spleen _____
( ) Urinary stone _____
( ) Breast _____
( ) Bladder _____
( ) Heart Bypass _____
( ) Umbilical hernia _____
( ) Hip replacement _____
( ) Prostate _____
( ) Gastric Bypass _____
( ) Kidney _____
( ) Thyroid _____
( ) Heart Valve _____
( ) Lung _____
( ) Appendectomy _____
( ) Gallbladder _____
( ) Incontinence _____
( ) Vasectomy/tubal ligation_____
( ) Testicular/Scrotal _____

Other: _____

Please identify any family history of medical problems and their relationship to you. (ex: father, mother, brother)

( ) Heart disease _____
( ) Prostate cancer _____
( ) Kidney tumors _____
( ) Bladder cancer _____
( ) Liver disease _____
( ) High blood pressure _____
( ) Kidney cysts _____
( ) Other cancer _____
( ) Sickle cell _____
( ) Kidney failure _____
( ) Kidney stones _____
( ) Anemia _____
( ) Diabetes _____
( ) Tuberculosis _____
( ) Cystic fibrosis _____

Adopted? Yes No

Other: _____

**Patient Name** _____ **Birth Date** _____

**Today's Date** _____

# REVIEW OF SYSTEMS

Have you recently had any problems related to the following:

## CONSTITUTIONAL

( ) Fever
( ) Chills
( ) Weight change
( ) Headache

## EYES

( ) Blindness
( ) Double vision
( ) Blurred vision
( ) Glaucoma open/closed

## NEUROLOGICAL

( ) Tremors
( ) Dizziness
( ) Numbness / Tingling
( ) Seizures

## ENDOCRINE

( ) Excessive thirst
( ) Tired/sluggish
( ) Too hot/cold
( ) Hair loss

## GASTROINTESTINAL

( ) Abdominal pain
( ) Diarrhea
( ) Nausea/vomiting
( ) Constipation
( ) Indigestion/heartburn
( ) Bloating

## CARDIOVASCULAR

( ) Chest pain
( ) Palpitations
( ) Irregular heart beat
( ) High blood pressure
( ) Heart failure

## INTEGUMENTARY

( ) Skin rash
( ) Boils/sores
( ) Persistent itch

## MUSCULOSKELETAL

( ) Joint pain/swelling
( ) Neck pain
( ) Back pain

## RESPIRATORY

( ) Cough
( ) Shortness of breath
( ) Wheezing
( ) Cough with blood

## IMMUNOLOGICAL

( ) Asthma
( ) Food allergies
( ) Hay fever
( ) Other: _____

## HEMATOLOGIC/LYMPHATIC

( ) Blood clotting problems
( ) Bruising
( ) Anemia
( ) Enlarged lymph nodes

## EARS / NOSE / THROAT

( ) Ringing in the ears
( ) Hearing loss
( ) Hoarseness / Sore throat
( ) Recurrent nose bleeds
( ) Ear infection

TEXAS UROLOGY SPECIALISTS

# AUTHORIZATION FOR RELEASE OF INFORMATION

DATE: _____

I, _____, give my permission for Texas Urology Specialists' physicians and/or staff to discuss my medical treatment, account information, and/or any test results with the following:

| **Individual's Name** | **Relationship** | **Phone Number** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*****Note to patient:** We are not able to release records or discuss your care with your spouse or family without a written release.*****

**THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.**

_____

*(Signature of Patient or Responsible Party)* *(Patient Date of Birth)*

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TEXAS UROLOGY SPECIALISTS

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Urology Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Urology Specialists.

Print Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

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**(TUS) Use Only**

Date acknowledgement received: _____ by: _____

-OR-

Reason not obtained:

_____

_____

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**Name: _____ Patient Birth Date: _____**

**Today's Date: _____**

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

**Preferred Language:** _____

**Circle Ethnicity:** **HISPANIC OR LATINO** **NOT HISPANIC OR LATINO**

**Circle Preferred Method of Contact:** Home phone Cell phone Work phone Email Mail Home Address

**Phone number not previous provided:** _____ **H C W (circle type)**

**Email address:** _____

**CIRCLE RACE**

| | | |
|---|---|---|
| AFRICAN AMERICAN | HMONG | PACIFIC ISLANDER NOS |
| ASIAN INDIAN PAKISTANI SRI LANKAN | JAPANESE | POLYNESIAN NOS |
| CAUCASIAN | KAMPUCHEAN CAMBODIAN | SAMOAN |
| CHAMORRAN | KOREAN | TAHITIAN |
| CHINESE | LAOTIAN | THAI |
| FIJI ISLANDER | MELANESIAN NOS | TONGAN |
| FILIPINO | MICRONESIAN NOS | VIETNAMESE |
| GUAMANIAN NOS | NATIVE AMERICAN | UNKNOWN |
| HAWAIIAN | NEW GUINEAN | |
| HISPANIC | OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS | |

Options/Values were selected by HITECH Act and Texas State Tumor Registry.