TEXAS UROLOGY SPECIALISTS

Michael Wierschem, M.D. • Huong Hegde, M.D.
Mitchell Moskowitz, M.D.

(Please Fill Out Completely)

Date_____

Home Phone#_____

Cell Phone # _____

Work Phone # _____

E-mail _____

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)*

Michael Wierschem, M.D • Huong Hegde, M.D • Mitchell Moskowitz, M.D
4708 Alliance Blvd Ste 650 • Plano, TX 75093 • T: 972-403-5425
5236 W. University Dr, Suite 4500 • McKinney, TX 75071 • T: 972-596-6733
7777 Forest Lane, Bldg C618 • Dallas, TX 75230 • T: 972-566-5400
www.TexasUrologySpecialists.com

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: _____

(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 **H**ome phone **C**ell phone **W**ork 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.