TEXAS UROLOGY SPECIALISTS

Michael Wierschem, M.D. • Huong Hegde, M.D.
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(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: ______________________ **DATE:** ___/___/_____ **MED REC #:** __________

DATE OF BIRTH: ___/___/_____ **AGE:** _____ **HEIGHT:** ____FT ____IN **WEIGHT:** _______LBS

Referring Physician: ______________ **Referring Physician's Phone #:** __________ **Referring Physician's Address:** ______________

Primary Care Physician (if Different) ______________________ **Phone #:** ______________

Race: ☐ White ☐ Black ☐ Hispanic / Latin ☐ Asian Other: ______________ Sex: ☐ Female ☐ Male

Marital/Family Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Previously widowed? ☐ Yes ☐ No Previous divorce? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No If so, number:_____

Reason for your visit today: ____

Pharmacy Name: ______________ **Address:** ______________ **City:** ______________ **Zip:** _______

Pharmacy Phone #: ______________________ **Pharmacy Fax #:** ______________________

Drug Allergies: ______________________________________ Reaction: ______________

Other Allergies: ______________________________________ Reaction: ______________

Medical History

	Yes	No
Angina (chest pain related to heart disease)	☐	☐
Anxiety	☐	☐
Arteriosclerosis (Hardening of the Arteries)	☐	☐
Arthritic Joints	☐	☐
Asthma	☐	☐
COPD	☐	☐
Depression	☐	☐
Deep Vein Thrombosis	☐	☐
Diabetes	☐	☐
Elevated Cholesterol	☐	☐
Gout	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
If yes, do you take antibiotics for dental procedures?	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HIV	☐	☐
Hypothyroid (Low Thyroid)	☐	☐
Kidney Stones	☐	☐
Pacemaker Placement	☐	☐
Parkinson's Disease	☐	☐
Pulmonary Emboli (Blood Clot in Lung)	☐	☐
Sickle Cell Trait/Disease	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Use of Coumadin	☐	☐
Valvular Heart Disease	☐	☐
Weight Loss	☐	☐

Other: ______________________

Medications: (continue on reverse side if more space is needed)

Name	Strength	Frequency
Daily use of aspirin? ☐ Yes ☐ No		

Family History

FAMILY HISTORY of kidney stones? ☐ Yes ☐ No

FEMALES ONLY

\# pregnancies _____ # children _____

Date of Last Menstrual Period? ____________

Date of Last PAP Smear? ____________

☐ Normal ☐ Abnormal

MALES ONLY

History of Prostate Infections ☐ Yes ☐ No

Family History of Prostate Cancer? ☐ Yes ☐ No

Date of your last prostate exam? ____________

Date of your last PSA test? ____________

Surgical History: (continue on reverse side if more space is needed)

Year	Operation	Hospital

Social History

Do you or have you smoked Cigarettes?
☐ Yes ☐ No ☐ Quit (Year____) # packs per day?___

Do you or have you used alcohol?
☐ Yes ☐ No ☐ Quit (Year____) # drinks per week? ___

Substance Abuse ☐ Yes ☐ No ☐ Quit (Year_____)

Coffee	Cups Per Day	0	1	2	3	4+
Tea	Cups Per Day	0	1	2	3	4+
Carbonated Drinks	Cans Per Day	0	1	2	3	4+
Water	Cups Per Day	0	1	2	3	4+

Exercise Activity: ______________________

Occupation: ______________________

FORM 102 REV 05/2011

Over the past month, how often have you:	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1.had a sensation of not emptying your bladder completely after urinating?	0	1	2	3	4	5
2.had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3.found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4.found it difficult to postpone urination?	0	1	2	3	4	5
5.had a weak urinary stream?	0	1	2	3	4	5
6.had to push or strain to begin urination?	0	1	2	3	4	5
7.most typically gotten up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	(number of times) 3	4	5
Total score ______						

PATIENT REVIEW OF SYSTEMS: Please mark all yes or no

Constitutional--☐Neg

	Yes	No
chills	O	O
fever	O	O

Respiratory--☐Neg

	Yes	No
dyspnea (shortness of breath)	O	O

Gastrointestinal-☐Neg

	Yes	No
diarrhea	O	O

Metabolic/Endocrine--☐Neg

	Yes	No
goiter	O	O

Musculoskeletal-☐Neg

	Yes	No
back pain	O	O

Heent---☐Neg

	Yes	No
double vision	O	O

Cardiovascular--☐Neg

	Yes	No
chest pain	O	O

Integumentary--☐Neg

	Yes	No
rash	O	O

Neurological--☐Neg

	Yes	No
syncope/fainting	O	O

Hema/Lymphatic-☐Neg

	Yes	No
easy bleeding	O	O
petechiae/easy bruising	O	O

Psychiatric--☐Neg

	Yes	No
anxiety	O	O

11 System ROS

☐ All Negative

Additional Information / Medications / Surgical History

____

____

____

____

FOR DOCTORS ONLY:

CHIEF COMPLAINT

PRESENT ILLNESS

PHYSICAL EXAM

PROCEDURES

LAB

OUTSIDE RECORDS

ASSESSMENT

PLAN

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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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 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.