TEXAS UROLOGY SPECIALISTS

(Please Fill Out Completely)

Date: _____

Home Phone#: _____
Cell Phone#: _____
Work Phone#: _____
E-mail: _____

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

Patient Last name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ ZIP: _____

Patient Employer: _____ Occupation: _____

Ok to release medical information? ☐ YES ☐ NO To the following person(s):

1. _____ 2. _____ 3. _____

Parent Name: _____ Parent Name: _____

Applies only to parents of minor children or children insured under the parents' insurance

*Cardiologist Doctor _____ Phone _____

*Referring Doctor: _____ Phone: _____

Primacy Care Doctor: _____ Phone: _____

Pharmacy Name/Location: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to emergency contact _____

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Indian/Pakistani/SriLankan ☐ Chamorran ☐ Chinese

☐ Fiji Islander ☐ Filipino ☐ GuamanianNOS ☐ Hawaiian ☐ Japanese Kampuchean/Cambodian ☐ Korean ☐ Laotian

☐ MelanesianNOS ☐ MicronesianNOS ☐ Samoan ☐ Tahitian ☐ Thai Tongan ☐ Vietnamese

☐ Other: _____

I understand that I am financially responsible for all the charges incurred including office expenses, laboratory fees, pathology fees, and outpatient/Inpatient procedure charges. This is to include all charges not covered by my medical insurance. I also understand that if my insurance requires a referral, I am responsible for obtaining the referral and keeping up with the expiration dates.

_____ _____

Patient's signature or Guardian's signature Date

MEDICAL HISTORY FORM

(please complete form)

Today's date: _____ Height: _____ Weight: _____

Name: _____ Birthdate: _____
(first name) (last name)

UROLOGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ Any pain or burning when voiding/urinating?
- ☐ Any urgency or need to run to the bathroom?
- ☐ Any urinary frequency or need to void many times during the night?
- ☐ Any sense of incomplete emptying of your bladder?
- ☐ Any leakage of urine?
- ☐ Any blood in urine?
- ☐ Any pain? If yes, where is your pain located? _____

Have you tried any medicine / treatment for this problem / pain? _____

CURRENT MEDICATIONS: LIST ALL MEDICATIONS – INCLUDING OVER THE COUNTER MEDS.

DRUG NAME	STRENGTH	DIRECTIONS/HOW YOU TAKE IT:

(ATTACH LIST IF NECESSARY)

ALLERGIES: ☐ YES ☐ NO _____

_____

NAME: _____ **DOB:** _____

REVIEW OF SYSTEMS: *CIRCLE ALL PROBLEMS YOU ARE CURRENTLY EXPERIENCING:*

CONSTITUTIONAL
Appetite Changes
Anorexia
Aches and Pains
Chills
Easy bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night sweats
Sleep Apnea
Swollen Glands
Weight Gain
Weight Loss

EYES
Blind
Blurred Vision
Double Vision
Glaucoma
Pain
Worsening Eyesight

ALLERGIC/IMMUNOLOGIC
Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

NEUROLOGICAL
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems

ENDOCRINE
Diabetes
Excessive Thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too hot/cold

GU
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Gas
Hemorrhoids
Indigestion/Heartburn
Irregular Bowel Movements
Nausea/Vomiting
Rectal Bleeding
Tarry Stool

CARDIOVASCULAR
Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Orthopnea
Palpitation
Skipped Heart Beats
Swelling
Pain/Cramp Hips-Legs w/Exercise

SKIN
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin Rash

MUSCULOSKELETAL
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

EAR/NOSE/THROAT
Ear infection
Sinus Problem
Sore Throat

GENITOURRINARY/UROLOGY
Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Bedwetting
Not Emptying
Painful Ejaculation
Stranguria
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge
Weak Stream

RESPIRATORY
Asthma
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of Breath
Tuberculosis
Wheezing

HEMATOLOGICAL/ LYMPHATIC
Swollen Glands
Blood Clotting Problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickie Cell

PSYCHOLOGIC
Anxiety
Depressed
Generally satisfied with life

NAME: _____ DOB: _____

PAST MEDICAL HISTORY: IF YES, please CIRCLE if you have or have had any of the following conditions:

CARDIOVASCULAR
Anemia
Angina
Aortic Aneurysm
Arrythmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication
Congestive Heart failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Disease
Heart Murmur
Hemophilia
Hypertension
Hypertension, severe
Mitral Valve Prolapse
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

OB/GYN
Breast Cancer
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids

HEENT
Blindness
Cataracts
Deafness
Ear Infections
Glaucoma
Mumps
Sinusitis
Tinnitus
Vertigo

ENDOCRINE
Diabetes Mellitus, Non-insulin dependent
Diabetes Mellitus, Insulin dependent
Goiter
Gout
Hyperthyroidism
Hypothyroidism

GENERAL
Allergies
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholesterolemia
Hyperlipidemia
Lipid Disorder Obesity
PCKD
PCO
Raynaud's Syndrome

MUSCOLOSKETAL
Arthritis
Back Pain
Carpal Tunnel Syndrome
Fibromyalgia
Mortons Neuroma

NEUROLOGICAL/PSYCHOLOGICAL
ADD
Alcoholism
Alzheimer's Disease
Anxiety
Chronic Fatigue Syndrom
Depression
Eating Disorder
Epilepsy
Herniated Disc
Migraine
Multiple Sclerosis
Parkinson's
Seizures
Spinal Cord Injury
Stroke

GI
Cholecystitis
Cholelithiasis
Chronic Liver Disease
Colitis
Constipation
Crohn's Disease
Diarrhea
Diverticulosis
GERD
Hemorrhoids
Hepatic Failure
Hepatitis
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis

RESPIRATORY
Asthma
Bronchitis
COPD
Emphysema
Pneumonia
Pulmonary Embolism
Tuberculosis

GU- Urological
AIDS
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Failure
Hematuria
Impotence of Organic Origin
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Infection
Kidney Stones
Sleep Apnea

GU- Urological
Libido Decreased
Nephrolithiasis
Neurogenic Bladder
Orchitis
Penile Discharge
Polycystic Disease
Prostate Cancer
Recurrent UTI
Renal Cell Cancer
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Transit Cell CA Bldr
Transit Cell CA Ureter
Undescended Testicle (Birth)
Urinary Tract Infection
Venereal Disease

TUMORS
Brain Cell Carcinoma
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Gastric Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Sarcoidosis
Testicular Cancer
Transitional Cell CA Bldr
Transitional Cell CA Ureter
Uterine CA

NAME: _____ **DOB:** _____

SURGICAL HISTORY: **IF YES, please list all surgeries including dates (MONTH/YEAR)**

NAME OF PROCEDURE	DATE

FAMILY HISTORY: **IF YES, please check box ☒ and indicate which family member has/had any of the following:** (Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

- ☐ Adrenal Disease _____
- ☐ Bedwetting _____
- ☐ Bladder Cancer _____
- ☐ Crohn's Disease _____
- ☐ Diabetes _____
- ☐ Gout _____
- ☐ Heart Attack _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Kidney Cancer _____
- ☐ Kidney Disease _____
- ☐ Kidney Stones _____
- ☐ Multiple Sclerosis _____
- ☐ Prostate Cancer _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Tuberculosis _____

SOCIAL HISTORY:

MARITAL STATUS:	DEPENDENTS - Please indicate number of each, if you have:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	_____ Sons _____ Daughters _____ Stephchildren _____ Adopted _____ Foster _____ Grandparents

1. **ALCOHOL CONSUMPTION:** None Yes Occasional/Social # of drinks per day _____
2. **TOBACCO:** ☐ None ☐ Yes # _____ packs/day _____ cigarettes/day ☐ Smokeless Tobacco
   ** If you previously stopped, when?
3. **RECREATIONAL DRUGS:** ☐ None ☐ Yes, Please list:
4. **CAFFEINATED BEVERAGES:** ☐ None ☐ Low ☐ Moderate ☐ Excessive

TEXAS UROLOGY SPECIALISTS

Consent for Purpose of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by Texas Urology Specialists for diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations. I understand that diagnosis or treatment of me by all doctors of Texas Urology Specialists may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" encompasses health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the practice's health care operations. Texas Urology Specialists is not required to agree to the restrictions that I may request, however, if Texas Urology Specialists agrees to a requested restriction, that restriction is binding on both the practice and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Texas Urology Specialists has acted in reliance on this consent.

I understand I have a right to review Texas Urology Specialists' **Notice of Privacy Practices** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or the performance of health care operations of Texas Urology Specialists. It also describes my rights and Texas Urology Specialists' duties with respect to my protected health information.

Texas Urology Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize Texas Urology Specialists to call my home or work to remind me of an appointment or to reschedule an appointment. I also authorize Texas Urology Specialists to leave scheduling information on my answering machine, or voicemail system.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

TEXAS UROLOGY SPECIALISTS

CANCELLATION & NO-SHOW POLICY

We strive to render excellent medical care to you and the rest of our patients, so we understand that situations arise in which you must cancel your appointment. To provide all of our patients with the highest level of care and access we request that all patients that need to cancel their appointment provide more than 24-hours' notice. This will enable us to better utilize available appointments for our patients.

Appointments cancelled with less than 24-hours or if the patient no-shows without notification may be subject to a cancellation fee. The cancellation fees are provided below based on type of appointment.

Office Visits	$ 50.00
In-Office procedures	$ 100.00
Hospital procedures	$ 250.00

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next scheduled appointment.

Please contact our office should you have any questions regarding the cancellation and no-show fees and we will be glad to assist.

Patient Name (please print)	**Date of Birth**
Patient Signature or Patient Representative	**Date**

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 regarding 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.

Name (Please Print): _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

Texas Urology Specialists Use Only

Date acknowledgement received: _____

- OR -

Reason acknowledgement was not obtained:

_____