

# BRAZOSPORT UROLOGY

TODAY'S DATE \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

SEX (CIRCLE ONE) Male — Female SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

MARITAL STATUS (CIRCLE ONE) Single / Married / Divorced / Separated / Widowed / Partner

PRIMARY CARE AND/OR REFERRING PHYSICIAN \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER OF PATIENT OR GUARANTOR \_\_\_\_\_

INFORMATION RELEASE: [Health information collected here about me may be disclosed to the following persons.]

NAME \_\_\_\_\_ RELATION \_\_\_\_\_

NAME \_\_\_\_\_ RELATION \_\_\_\_\_

***IF THE PATIENT IS UNDER THE AGE OF 18:***

RESPONSIBLE PARTY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PLEASE TELL US HOW YOU HEARD ABOUT US: \_\_\_\_\_

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to the above named doctor/group for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I hereby assign benefits to the doctor or group indicated on this claim. I understand that I am responsible for the co-pay at time of visit. Having insurance is not a substitute for payment. I further understand that if my benefits are not verifiable, I might be responsible for charges in full with a possible reimbursement after verification is obtained. A copy of this signature is as valid as the original.

By signing this I also acknowledge that I have read and understand Brazosport Urology's Notice of Privacy Practices. A copy is located in the lobby and will be given to a patient upon request. I authorize the person(s) listed above to receive all health information about appointments, treatments and/or other information pertinent to my health care provided by Brazosport Urology.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. We cannot be responsible for any loss of benefits. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.

***If you do not show up for your appointment without 24-hour advance notice cancelling, you will be charged up to \$250. This is done in order to preserve the schedule. Thank you.***

Signature of Patient or Guarantor \_\_\_\_\_ Date \_\_\_\_\_

## **Health History**

Allergies (drug, food, contrast and reactions) \_\_\_\_\_

**Past Medical History :** \_\_\_\_\_

**Past Surgical History:** \_\_\_\_\_

**Other Hospitalizations:** \_\_\_\_\_

*Please list any pharmaceutical and/or natural medications (including vitamins) that your are taking or have taken in the last year*

Medications	Dosage	Reason for taking

**Do you take any of the following over-the-counter medications? Please check or circle any that apply:**

Aspirin     Ibuprofen / Acetaminophen     Antihistamine     Sleeping pills  
 Laxatives     Head /Cold Remedies     Antacid     Medicine to stay awake

Do you drink caffeine if so please circle one (tea, soda, coffee)? If so how much? \_\_\_\_\_

**Family History-(cancers or early deaths )** \_\_\_\_\_

Do you smoke or did you ever? \_\_\_\_\_ How much? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_ Any other illicit drugs? \_\_\_\_\_

### **Review of Systems**

Circle all following below areas in which you have had problems (**not previously mentioned above**):

Heart            Lung            Muscles/Bones            Endocrine (thyroid, diabetes, etc)            Stroke  
Skin            Emotional            Gastrointestinal            Kidney            Constipation            Recent Weight Loss

Please explain any of the above \_\_\_\_\_

**FOR MEN ONLY**

Have you ever had an abnormal prostate exam? \_\_\_\_\_ If yes, did you have a prostate biopsy? \_\_\_\_\_

If so, when and where? \_\_\_\_\_

**FOR WOMEN ONLY**

Last menses or Menopause \_\_\_\_\_ Number of pregnancies \_\_\_\_\_

Number of Vaginal deliveries \_\_\_\_\_ Number of caesarian sections \_\_\_\_\_

Have you seen a Urologist before? \_\_\_\_\_ If so when? \_\_\_\_\_

For what reason? \_\_\_\_\_

What is your most important reason for making this appointment? \_\_\_\_\_

List any other Urological concerns you may have \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOR DOCTOR USE ONLY:**

\_\_\_\_ FREQUENCY

\_\_\_\_ DYSURIA

\_\_\_\_ NOCTURIA

\_\_\_\_ URGENCY

\_\_\_\_ HESITANCY

\_\_\_\_ LEAKAGE

\_\_\_\_ STREAM

\_\_\_\_ SUI

\_\_\_\_ PVD

\_\_\_\_ UI

\_\_\_\_ STRAIN

\_\_\_\_ SOAKED/DAMP

\_\_\_\_ PAD / LINER

\_\_\_\_ STONES

\_\_\_\_ UTI'S

\_\_\_\_ DISCHARGE

\_\_\_\_ HEMATURIA/GROSS \_\_\_\_\_