

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Patient’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_ Spouse’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name and Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party (If not Patient)**

Person responsible for bill: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient History**

Why are you seeing the doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** (Please list ALL): (NONE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Medical History** (Please Check if you have had any of the following):

**Cardiovascular**

[ ]  Anemia

[ ]  Angina (Chest pain)

[ ]  Aortic Aneurysm

[ ]  Irregular heartbeat

[ ]  Atrial Fibrillation

[ ]  Bleeding Disorder

[ ]  Cerebrovascular Disease / Stroke

[ ]  Congestive Heart Failure

[ ]  Coronary Artery Disease

[ ]  Deep Vein Thrombosis (Blood clots)

[ ]  Heart Attack

[ ]  Heart Murmur

[ ]  Heart Valve Problem / Replacement

[ ]  Hypertension (High Blood Pressure)

[ ]  Mitral Valve Prolapse

[ ]  Sickle Cell Anemia

[ ]  Thrombophlebitis

**Endocrine/Metabolic**

[ ]  Diabetes (Non-Insulin Dependent)

[ ]  Diabetes (Insulin Dependent)

[ ]  Gout

[ ]  Hyperthyroidism (High)

[ ]  Hypothyroidism (Low)

**General**

[ ]  Allergies

[ ]  Hernia Location: \_\_\_\_\_\_

[ ]  High Cholesterol

[ ]  Malaise (Weak / Tired)

[ ]  Sleep Apnea

**GI**

[ ]  Cholelithiasis (Gallstones)

[ ]  Colitis

[ ]  Constipation

[ ]  Crohn’s Disease

[ ]  Diarrhea

[ ]  Divericulosis

[ ]  GERD (Acid Reflux, Indigestion)

[ ]  Hemorrhoids

[ ]  Hepatitis

[ ]  Inflammatory Bowel Disease

[ ]  Peptic Ulcer

[ ]  Ulcerative Colitis

**GU**

[ ]  HIV or AIDS

[ ]  Bladder Stone

[ ]  Bladder Infection (UTI)

[ ]  Chronic Renal Insufficiency

[ ]  Erectile Dysfunction

[ ]  Hematuria (Blood in the Urine)

[ ]  Interstitial Cystitis

[ ]  Radiation Therapy

[ ]  Kidney Infection

[ ]  Kidney Stones

[ ]  Neurogenic Bladder

[ ]  Orchitis (Testicle Infection)

[ ]  Polycystic Kidney Disease

[ ]  Recurrent UTI

[ ]  Undescended Testicle

**Gynecology/Obstetrics**

[ ]  Endometriosis

[ ]  Menopause

[ ]  Osteoporosis

[ ] Uterine Fibroids

**ENT**

[ ]  Blindness

[ ]  Cataracts

[ ]  Glaucoma

[ ]  Mumps

**Musculoskeletal**

[ ]  Arthritis

[ ]  Back Pain

[ ]  Fibromyalgia

**Neurology/Psychiatric**

[ ]  Alcoholism

[ ]  Alzheimer’s Disease

[ ]  Anxiety

[ ]  Bipolar Disorder

[ ]  Chronic Fatigue Syndrome

[ ]  Depression

[ ]  Epilepsy

[ ]  Migraine

[ ]  Multiple Sclerosis

[ ]  Parkinson’s Disease

[ ]  Spinal Cord Injury

[ ]  Stroke

**Respiratory**

[ ]  Asthma

[ ]  Bronchitis

[ ]  Emphysema (COPD)

[ ]  Pneumonia

[ ]  Pulmonary Embolism

[ ]  Tuberculosis (TB)

**Oncology**

[ ]  Bladder Tumor

[ ]  Brain Tumor

[ ]  Breast Cancer

[ ]  Cervical Cancer

[ ]  Colon Cancer

[ ]  Lung Cancer

[ ]  Lymphoma

[ ]  Melanoma

[ ]  Ovarian Cancer

[ ]  Prostate Cancer

[ ]  Kidney Cancer

[ ]  Testicular Cancer

**Initial Here if you have no Medical Problems:** \_\_\_\_\_\_\_\_\_\_\_\_

**Please List any other Diseases or Conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Surgical History** (Please Check if you have had any of the following and indicate the year of surgery):

**Cardiovascular**

[ ] \_\_\_\_\_\_\_Angioplasty

[ ] \_\_\_\_\_\_\_Aortic Aneurysm Repair

[ ] \_\_\_\_\_\_\_CABG

[ ] \_\_\_\_\_\_\_Carotid Artery Surgery

[ ] \_\_\_\_\_\_\_Heart Stents

[ ] \_\_\_\_\_\_\_Heart Transplant

[ ] \_\_\_\_\_\_\_Pacemaker

[ ] \_\_\_\_\_\_\_Artificial Heart Valve

**GI**

[ ] \_\_\_\_\_\_\_Appendectomy

[ ] \_\_\_\_\_\_\_Weight Loss Surgery

[ ] \_\_\_\_\_\_\_Bowel Resection

[ ] \_\_\_\_\_\_\_Gall Bladder Removal

[ ] \_\_\_\_\_\_\_Colon Resection

[ ] \_\_\_\_\_\_\_Colonoscopy

[ ] \_\_\_\_\_\_\_EGD

[ ] \_\_\_\_\_\_\_Fissurectomy

[ ] \_\_\_\_\_\_\_Hemorrhoidectomy

[ ] \_\_\_\_\_\_\_Ileostomy

[ ] \_\_\_\_\_\_\_Inguinal Hernia

[ ] \_\_\_\_\_\_\_Laparoscopy

[ ] \_\_\_\_\_\_\_Liver Surgery

[ ] \_\_\_\_\_\_\_Lysis of Adhesions

[ ] \_\_\_\_\_\_\_Splenectomy

[ ] \_\_\_\_\_\_\_Umbilical Hernia Repair

[ ] \_\_\_\_\_\_\_Ventral Hernia Repair

**Urologic**

[ ] \_\_\_\_\_\_\_Bladder Surgery

[ ] \_\_\_\_\_\_\_Prostate Biopsy

[ ] \_\_\_\_\_\_\_Brachytherapy (Seed Implant)

[ ] \_\_\_\_\_\_\_Circumcision

[ ] \_\_\_\_\_\_\_Cystoscopy

[ ] \_\_\_\_\_\_\_Urethral Dilation

[ ] \_\_\_\_\_\_\_Ureteral Stent Placement

[ ] \_\_\_\_\_\_\_Epididymectomy

[ ] \_\_\_\_\_\_\_ESWL (Shockwave Stones)

[ ] \_\_\_\_\_\_\_Hydrocelectomy

[ ] \_\_\_\_\_\_\_Ileal Conduit

[ ] \_\_\_\_\_\_\_Interstim

[ ] \_\_\_\_\_\_\_Laser Kidney Stone Surgery

[ ] \_\_\_\_\_\_\_Kidney Removal

[ ] \_\_\_\_\_\_\_Nephrolithotomy

[ ] \_\_\_\_\_\_\_Testicle Removal

[ ] \_\_\_\_\_\_\_Penile Implant / Prosthesis

[ ] \_\_\_\_\_\_\_Penectomy

[ ] \_\_\_\_\_\_\_Pyeloplasty

[ ] \_\_\_\_\_\_\_Prostate Removal for Cancer

[ ] \_\_\_\_\_\_\_Kidney Transplant

[ ] \_\_\_\_\_\_\_Spermatocelectomy

[ ] \_\_\_\_\_\_\_Prostate Microwave

[ ] \_\_\_\_\_\_\_Urolift

[ ] \_\_\_\_\_\_\_Laser Surgery on Prostate

[ ] \_\_\_\_\_\_\_TURP

[ ] \_\_\_\_\_\_\_Bladder Tumor Removal

[ ] \_\_\_\_\_\_\_Varicocelectomy

[ ] \_\_\_\_\_\_\_Vasectomy

**Gynecology**

[ ] \_\_\_\_\_\_\_C-Section

[ ] \_\_\_\_\_\_\_Hysterectomy

[ ] \_\_\_\_\_\_\_Removal of Ovaries

[ ] \_\_\_\_\_\_\_Tubal Ligation

**ENT**

[ ] \_\_\_\_\_\_\_Cataract Surgery

[ ] \_\_\_\_\_\_\_Eye Surgery

[ ] \_\_\_\_\_\_\_Facial Surgery

[ ] \_\_\_\_\_\_\_Nasal Surgery

[ ] \_\_\_\_\_\_\_Sinus Surgery

[ ] \_\_\_\_\_\_\_Tonsil Surgery

[ ] \_\_\_\_\_\_\_Thyroid Surgery

[ ] \_\_\_\_\_\_\_Parathyroid Surgery

**Musculoskeletal**

[ ] \_\_\_\_\_\_\_Amputation

[ ] \_\_\_\_\_\_\_Knee Surgery

[ ] \_\_\_\_\_\_\_Carpal Tunnel Surgery

[ ] \_\_\_\_\_\_\_Neck Surgery

[ ] \_\_\_\_\_\_\_Foot Surgery

[ ] \_\_\_\_\_\_\_Hand Surgery

[ ] \_\_\_\_\_\_\_Hip Surgery

[ ] \_\_\_\_\_\_\_Leg Surgery

[ ] \_\_\_\_\_\_\_Shoulder Surgery

[ ] \_\_\_\_\_\_\_Spine Surgery

[ ] \_\_\_\_\_\_\_Back Surgery

[ ] \_\_\_\_\_\_\_Disc Surgery

**Respiratory**

[ ] \_\_\_\_\_\_\_Lung Surgery

**Skin**

[ ] \_\_\_\_\_\_\_Basal Cell Carcinoma

[ ] \_\_\_\_\_\_\_Melanoma

[ ] \_\_\_\_\_\_\_Squamous Cell Carcinoma

[ ] \_\_\_\_\_\_\_Pilonidal cyst

[ ] \_\_\_\_\_\_\_Skin Graft

**Initial Here if you have had no surgeries:** \_\_\_\_\_\_\_\_\_\_\_\_

**Please List any other surgeries and their dates:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History** (please indicate if any family members have had any of the following conditions):

Prostate Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bladder Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Stones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Failure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Alcohol Consumption: [ ] None [ ]  Occasional/Social Number Drinks per Day: \_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use: [ ]  None Packs Per Day: \_\_\_\_\_\_\_ Cigarettes Per Day: \_\_\_\_\_\_ [ ]  Smokeless Tobacco

If you previously smoked, when did you quit? \_\_\_\_\_\_ How many years did you smoke? \_\_\_\_\_\_ Packs per day? \_\_\_\_\_\_

Caffeinated Beverages: [ ] None [ ] 1-2 per day [ ] 3-4 per day [ ] 5 or more per day

Recent Foreign Travel: [ ] None Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic History:**

Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Vaginal Deliveries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**

**Are you on any blood thinners (aspirin, Plavix, coumadin, warfarin, Eliquis, Xarelto)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name Dosage Directions/How you take it

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Review of Systems:**

Do you have any of the following symptoms?

**General**

[ ]  Fever

[ ]  Chills

[ ]  Sweats

[ ]  Weakness

[ ]  Malaise

[ ]  Abnormal Weight Loss

[ ]  Sleep Disturbance

**ENT**

[ ]  Double Vision

[ ]  Blurred Vision

[ ]  Eye Irritation

[ ]  Eye Discharge

[ ]  Vision Loss

[ ]  Eye Pain

[ ]  Light Sensitivity

[ ]  Earache

[ ]  Ringing in Ears

[ ]  Nasal Congestion

[ ]  Nosebleeds

[ ]  Sore Throat

[ ]  Difficulty Swallowing

[ ]  Hearing Loss

**Cardiac**

[ ]  Chest Discomfort

[ ]  Chest Pain

[ ]  Palpitations

[ ]  Fainting

[ ]  Numbness in Arms

[ ]  Swelling of Limbs

**Respiratory**

[ ]  Cough

[ ]  Shortness of Breath

[ ]  Wheezing

[ ]  Chest Congestion

[ ]  Asthma

**Gastrointestinal**

[ ]  Nausea

[ ]  Vomiting

[ ]  Diarrhea

[ ]  Constipation

[ ]  Abdominal Pain

[ ]  Blood in Stool

[ ]  Heartburn

**Genitourinary**

[ ]  Painful Urination

[ ]  Blood in Urine

[ ]  Urinary Frequency

[ ]  Urinary Hesitancy

[ ]  Incontinence

**Musculoskeletal**

[ ]  Back Pain

[ ]  Joint Pain

[ ]  Joint Swelling

[ ]  Muscle Soreness

[ ]  Arthritis

**Skin**

[ ]  Sensation Disturbance

[ ]  Bruising

[ ]  Rash

[ ]  Itching

[ ]  Dryness

[ ]  Suspicious lesions

**Neurological**

[ ]  Headaches

[ ]  Memory Loss

[ ]  Confusion

[ ]  Transient Paralysis

[ ]  Weakness

[ ]  Numbness

[ ]  Tingling

[ ]  History of Seizures

[ ]  Tremors

[ ]  Dizziness

**Psychiatric**

[ ]  Depression

[ ]  Anxiety

[ ]  Memory Loss

[ ]  Mental Disturbances

[ ]  Suicidal Thoughts

[ ]  Mood Disorders

[ ]  Paranoia

[ ]  Sleep Disturbances

[ ]  Eating Disorder

**Endocrine**

[ ]  Sensitivity to Cold

[ ]  Sensitivity to Heat

[ ]  Abnormal Weight Gain

[ ]  Excessive Thirst

[ ]  Excessive Urination

[ ]  Excessive Hunger

[ ]  Diabetes

**Hematologic / Lymphatic**

[ ]  Chronic Infections

[ ]  Abnormal Bruising

[ ]  Bleeding

[ ]  Enlarged Lymph Nodes

**Allergic / Immunologic**

[ ]  Hives

[ ]  Hay Fever

[ ]  Persistent Infections

[ ]  HIV Exposure

[ ]  Runny Nose

[ ]  Sinus Congestion

**Extremities**

[ ]  Redness of a Limb

[ ]  Swelling of a Limb

[ ]  Discoloration of a Limb



**GENERAL CONSENT FOR TREATMENT**

I have voluntarily sought treatment for a specific illness or condition requiring diagnostic, medical, or surgical procedures. I hereby do voluntarily consent to such procedures and care and to such medical, surgical, or other services under the general and specific instructions of Dr. Darren Chapman, his assistants, or his designee as is necessary in his judgement.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination.

**POLICY EXCLUSIONS**

I understand there is a possibility that there are diagnosis exclusions: services that insurance companies will not pay for. Examples are, but are not limited to, erectile dysfunction and infertility. If I am being seen for an excluded diagnosis, I understand that I will be responsible for payment in full

**RELEASE OF MEDICAL INFORMATION**

I hereby authorize Dr. Darren Chapman to furnish treatment to me and to release information to the insurance carriers concerning my illness, and I do hereby irrevocably assign to the doctor all payment for medical services rendered. I understand that I am financially responsible for charges whether or not covered by insurance.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of Pearland Urology Notice of Privacy Practices.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION**

1. Please list the family members or other persons, if any, whom we may inform about:
	1. Your general medical condition and your diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Your medical condition ONLY IN AN EMERGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	3. Your FINANCIAL INFORMATION ONLY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Can confidential messages (i.e. Appointment reminders) be left on your home answering machine or voicemail? (Yes/No) \_\_\_\_\_\_\_\_\_\_
3. If you do not have voicemail, can a confidential message be left at your place of employment? (Yes/No) \_\_\_\_
4. Can confidential messages (i.e. Appointment reminders) be sent via e-mail? (Yes/No) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

I have an Advanced Directive on file: Yes or No I have a Medical Power of Attorney on file: Yes or No



**Vasectomy Cancellation/Reschedule Policy**

 At Pearland Urology, we understand that sometimes life gets in the way of getting your vasectomy. We ask that you give us **1 weeks’ notice** prior to your scheduled procedure to cancel or reschedule. **If you give us 1 weeks’ notice, you may cancel or reschedule without any consequences**.

 We do not charge a fee or penalty for failing to give us 1 weeks’ notice to cancel or reschedule your procedure.

 However, if you do not give us 1 weeks’ notice, we do require a **$200 deposit** to put you back on the vasectomy schedule. **This $200 deposit will be returned to you if you then proceed to have your vasectomy done at the rescheduled date and time**.

 Please note – **this is important!** – once you place your deposit and you are back on the schedule, **your date and time are not allowed to be changed again for any reason**. This includes medical emergencies and Acts of God. If you miss your appointment for your procedure, you will forfeit your $200 deposit and **we will not put you back on the schedule again**. You will have to go somewhere else for your vasectomy. Please note that “missing your appointment” includes arriving more than 20 minutes late for your procedure.

 **By signing below, you agree that you understand and will abide by this policy**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Insurance Payment Policy

Unfortunately, we have recently seen a significant rise in our number of unpaid insurance claims.

Before we provide medical services to a patient, we contact that patient’s insurance company to get a quote for the patient to let him know how much it will cost. Recently, we have been receiving incorrect information from insurance companies. The insurance companies will deny the bill for the rendered services, despite previously informing us that they would pay it. This has led to “surprise bills” for patients that in most instances have gone unpaid.

Because of the insurance companies’ new game of “retroactively denying claims,” Pearland Urology has been forced to put in place a credit card hold policy. We will keep the patient’s credit card information on file, and, should the patient’s insurance company deny payment, we will charge the patient’s credit card for the services rendered.

Please read and sign the following agreement:

Patient Statement:

“I understand that Dr. Chapman’s office has contacted my insurance company on my behalf to get a quote for my health care services. I understand that sometimes these quotes provided by my insurance company are inaccurate. I agree that should my insurance company not remit complete payment of the contracted rate for my health care services to Dr. Chapman, then Dr. Chapman has my authorization to charge my credit card for any balance from this date forward, until I revoke the authorization in writing. I allow Dr. Chapman to keep my credit card information on file for this purpose.”

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_