UROLOGY CARE SPECIALISTS

1601 CLINT MOORE ROAD, SUITE 195
BOCA RATON, FL 33487

PATIENT INFORMATION FORM - PLEASE PRINT CLEARLY

FIRST NAME	**LAST NAME**	**SOCIAL SECURITY NUMBER**
LOCAL ADDRESS		**MALE/FEMALE**
CITY	**STATE**	**ZIP CODE**
HOME PHONE	**CELL PHONE**	**EMAIL**
OUT OF TOWN ADDRESS		
CITY, STATE, ZIP CODE		**OUT OF TOWN PHONE NUMBER**
EMERGENCY CONTACT NAME		**EMERGENCY CONTACT PHONE NUMBER**
PATIENT'S DATE OF BIRTH	**AGE**	
MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED		**SPOUSE'S NAME**
OCCUPATION	**EMPLOYER**	**EMPLOYER PHONE NUMBER**
REFERRED BY		

INSURANCE INFORMATION

PRIMARY INSURANCE: ❑ MEDICARE ❑ OTHER:	**POLICY NUMBER/GROUP NUMBER**
INSURED PARTY: ❑ SELF ❑ SPOUSE ❑ OTHER:	**SS NUMBER OF INSURED PARTY (Optional)**
SECONDARY INSURANCE: ❑ MEDICARE ❑ OTHER:	**POLICY NUMBER/GROUP NUMBER**
INSURED PARTY: ❑ SELF ❑ SPOUSE ❑ OTHER:	**SS NUMBER OF INSURED PARTY (Optional)**

INSURANCE INFORMATION ________________ **(I have reviewed all the information below and it is accurate)**
Patient Initials

Primary Insurance:____ **PLAN ID:**______________________________

GROUP #:____

Secondary Insurance:____ **PLAN ID:**______________________________

GROUP #:____

PATIENT SIGNATURE **DATE**

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PATIENT HISTORY FORM

Primary Physician____ Tel #:____________________

Cardiologist____ Tel #:____________________

Primary Pharmacy Name____________________________________ Tel#:____________________

CHIEF COMPLAINT

What is the reason for your visit?____

____

When did you notice the problem?____

____

Where is the problem located?____

____

What makes it better or worse?____

____

Do you have any allergies? (Please check all that apply)

❑ Medications____

❑ Foods ____

❑ Iodine ❑ I.V. Contrast ❑ Shell Fish ❑ Other________________________

Please list ALL the medications you are currently taking:

Medication	Daily Dose and Frequency	Frequency

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FAMILY MEDICAL HISTORY

Patient's Name:______________________________

Today's Date;______________________________

Please mark who in your family has had the following:

- Alcoholism? YES NO Who?______________________
- Anemia? YES NO Who?______________________
- Anxiety? YES NO Who?______________________
- Arthritis? YES NO Who?______________________
- Cancer? YES NO Who?______________________
- Cardio / Vascular YES NO Who?______________________
- Cataracts? YES NO Who?______________________
- Diabetes? I or II? YES NO Who?______________________
- Hyperlipidemia? YES NO Who?______________________
- HTN? YES NO Who?______________________
- Kidney Stones? YES NO Who?______________________
- Stroke? YES NO Who?______________________

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CURRENT MEDICAL CONDITIONS

PLEASE MARK ANY PRIOR OR CURRENT MEDICAL CONDITIONS.

Cancer / Malignancy
- ❑ Breast Cancer
- ❑ Cervical/Uterine/Ovarian Cancer
- ❑ Colon/Rectal/Bowel Cancer
- ❑ Head or Neck Cancer
- ❑ Lung Cancer
- ❑ Prostate Cancer
- ❑ ______________________________

Endocrine
- ❑ Diabetes
- ❑ Hyperthyroidism
- ❑ Hypogonadism
- ❑ Hypothyoidism
- ❑ Obesity
- ❑ ______________________________

Hematologic
- ❑ Anemia
- ❑ Blood Clotting Disorders
- ❑ Leukemia
- ❑ Lymphoma
- ❑ ______________________________

Neurologic
- ❑ Brain Injury
- ❑ Dementia
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Neuropathy
- ❑ Spinal Stenosis
- ❑ Stroke or TIA
- ❑ ______________________________

Cardiovascular / Heart
- ❑ Heart Arrythmia
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Heart Valve Condition/Replacement
- ❑ High Cholesterol/Hyperlipidemia
- ❑ High Blood Pressire / Hypertension
- ❑ Heart Murmur
- ❑ ______________________________

Gastrointestinal
- ❑ Crohn's Disease/Ulcerative Colitis
- ❑ Diverticulitis
- ❑ Heartburn/Reflux Disease
- ❑ Irritable Bowel Syndrome
- ❑ Pancreatitus
- ❑ Ulcers
- ❑ ______________________________

Musculoskeletal
- ❑ Arthritis
- ❑ Back Pain
- ❑ Fibromyalgia
- ❑ Osteoporosis
- ❑ ______________________________

Respiratory
- ❑ Asthma
- ❑ COPD Emphysema
- ❑ Pulmonary Edema
- ❑ Pulmonary Embolism
- ❑ Sleep Apnea
- ❑ ______________________________

Dermatologic
- ❑ Cellulitis
- ❑ Skin Cancer
- ❑ Dermatitis
- ❑ ______________________________

Head / Eyes / Nose / Throat
- ❑ Allergic Rhinitis
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Migraine
- ❑ Sinus Condition
- ❑ ______________________________

Psychologic
- ❑ Alcoholism
- ❑ Anxiety Disorder
- ❑ Depression
- ❑ ______________________________

Sexually Transmitted Infections
- ❑ Herpes
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ HIV
- ❑ ______________________________

Urologic
- ❑ Bladder Cancer
- ❑ BPH/Enlarged Prostate
- ❑ Hematuria/Blood in Urine
- ❑ Incontinence
- ❑ Kidney Stones
- ❑ Recurrent Urinary Infections
- ❑ Renal Failure/Insufficiency
- ❑ Erectile Dysfunction
- ❑ ______________________________

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HISTORY

Family History: Urology Specific

Is there any family history of:
- ❑ Bladder Cancer____________________ ❑ Prostate Cancer____________________
- ❑ Kidney Cancer_____________________ ❑ Kidney Disease____________________
- ❑ Bladder Stones____________________ ❑ Kidney Stones____________________
- ❑ Testicular Cancer____________________

Social History:

Do you use alcohol? ❑ Yes ❑ No If yes, how many drinks per week? ______________________________

Do you use tobacco? ❑ Yes ❑ No If yes, how many packs per week?______________________________

Do you use recreational drugs? ❑ Yes ❑ No If yes, ______________________________

Level of education: ❑ High School/GED ❑ College ❑ Graduate Degree ❑ Trade/Vocational

Employment: ❑ Homemaker ❑ Self Employed ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Retired

What is your occupations?______________________________

Do you have children? ❑ Yes ❑ No If yes, how many?______________________________

Marital Status: ❑ Widowed ❑ Separated ❑ Single ❑ Divorced ❑ Married ❑ Significant Other

Review of Systems: Circle or check any that apply.

Allergic Symptoms: ❑ itchy eyes ❑ sensitivity to dust ❑ sneezing ❑ seafood allergy

Bleeding Probems: ❑ anemia ❑ easy bruising ❑ transfusion ❑ frequent nose bleeds

Breathing/Respiratory: ❑ asthma ❑ cough ❑ sleep apnea ❑ snoring ❑ shortness of breath

Cardiovascular: ❑ ankle swelling ❑ chest pain ❑ heart palpitations

General: ❑ fever ❑ chills ❑ nausea ❑ dizziness ❑ fatigue ❑ night sweats

Endocrine: ❑ heat/cold intolerance ❑ flushing ❑ dry skin ❑ excess thirst ❑ dry mouth

Eye Vision: ❑ blurred vision ❑ glasses/contacts ❑ loss of vision

Gastrointestinal: ❑ abdominal pain ❑ constipation ❑ heartburn ❑ diarrhea

Urologic/Urinary: ❑ blood in urine ❑ dribbling ❑ burning with urination ❑ low libido ❑ frequency
❑ urgency ❑ hesitancy ❑ interruption of urine flow ❑ testicular pain

Musculoskeletal: ❑ back pain ❑ muscle cramps ❑ leg pain ❑ joint swelling

Neurologic: ❑ confusion ❑ dizziness ❑ headache ❑ vertigo

Psychiatric: ❑ depression ❑ anxiety ❑ panic attacks ❑ stress

Skin: ❑ rash ❑ non-healing wound ❑ change in skin lesion ❑ blister

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PRIOR SURGERY

Please mark any prior surgeries and write year next to surgery:

Abdominal Surgery: ❑ Abdominal Aneurysm Repair

❑ Appendectomy____________________ ❑ Cholecystectomy_________________________________

❑ Colon/Intestinal Surgery_____________ ❑ Hernia Repair___________________________________

❑ Orthopedic Surgery_________________ ❑ Other____

Cardiovascular Surgery: ❑ Angioplasty/Stent__________ ❑ Coronary Bypass________ ❑ Carotid Endarterectomy_______

❑ Lung Surgery/Resection_____ ❑ Pacemaker Implant_______ ❑ Vascular Surgery/Stent_______

❑ ____

Ear, Nose, Throat: ❑ Tonsils____

❑ Sinus____

❑ Other____

Gynecologic/Breast: ❑ Breast Implant, Reconstruction, Reduction__________________ ❑ Breast Cancer Surgery_______

❑ C-Section___________________ ❑ Gynecologic Surgery______ ❑ Hysterectomy_______________

❑ Other____

Urologic Surgery: ❑ Kidney Surgery/Removal ❑ Removal of Kidney Stones ❑ Bladder Tumor Removal

❑ Prostate Surgery______________ ❑ Vasectomy_________________

❑ Urology Surgery______________ ❑ Botox______________________

Have you had chemotherapy or radiation therapy? ❑ Yes ❑ No If yes, when______________why___________________

Other:____

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MEDICATION HISTORY CONSENT FORM

I, ______________________________________, hereby authorization the office Urology Care Specialists to E-Prescribe medications as well as view my medication history.

This authorization will last indefinitely unless this office is notified in writing about any charges.

Signature____ Date________________________

Print____

Witness____

PLEASE PROVIDE YOUR PHARMACY INFORMATION BELOW

PHARMACY NAME____

PHONE NUMBER OR LOCATION_______________________________________

____