



(Please Fill Out Completely)

Date 07/18/2024

Home Phone# _____

Cell Phone # 817-507-9269

Work Phone # _____

E-mail johnnypate@gmail.com

Date of Birth 03/04/1972 Age 52 Marital Status: M S D W Male Female

Last Name Pate First Johnny Middle Lee

Address: 4636 N Josey Ln Apt 1916

City Carrollton State Texas ZIP 75010

Patient Employer McKesson Occupation Accounting Manager

Spouse Name _____ Ok to release Medical Information to spouse? Yes No

Emergency Contact Greg Sherman Phone _____

Pharmacy Name / Location Walgreen's E Hebron Pkwy, Carrollton Phone 972-939-1977

Primary Care Doctor Dr. Vikas Bhushan Phone 972-566-7790

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: Passed Kidney stone and was referred to incase there may be other issues.

Pharmacy Name: Walgreen's Address: 1804 E Hebron Pkwy City: Carrollton Zip: 75010
 Pharmacy Phone #: 972-939-1977 Pharmacy Fax #: _____
 Drug Allergies: None Reaction: _____
 Other Allergies: None Reaction: _____

Medical History

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

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

Name	Strength	Frequency
Daily use of aspirin? ☐ Yes ☒ No		
<u>Jakafi 10mg twice per day</u>		
<u>Pantoprazole 40mg Tablets once daily</u>		
<u>Acyclovir 400mg Tablets twice per day</u>		

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
<u>2014</u>	<u>Stem Cell Transplant</u>	<u>Medical City Dallas</u>
<u>2014</u>	<u>Gallbladder removal</u>	<u>Medical City Dallas</u>
<u>2018</u>	<u>Sleeve gastrectomy</u>	<u>Medical City Dallas</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 2020) # 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: Walking around 3 to 4 times a week
 Occupation: Accounting Manager

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 ☐ ☐ fever ☐ ☐	Respiratory--☐Neg Yes No dyspnea ☐ ☐ (shortness of breath)	Gastrointestinal--☐Neg Yes No diarrhea ☐ ☐	Metabolic/Endocrine--☐Neg Yes No goiter ☐ ☐	Musculoskeletal--☐Neg Yes No back pain ☐ ☐
Heent--☐Neg Yes No double vision ☐ ☐	Cardiovascular--☐Neg Yes No chest pain ☐ ☐	Integumentary--☐Neg Yes No rash ☐ ☐	Neurological--☐Neg Yes No syncope/fainting ☐ ☐	Hema/Lymphatic--☐Neg Yes No easy bleeding ☐ ☐ petechiae/easy ☐ ☐ bruising

Additional Information / Medications / Surgical History

Psychiatric--☐Neg
 Yes No
 anxiety ☐ ☐

11 System ROS
☐ All Negative

FOR DOCTORS ONLY:

CHIEF COMPLAINT

PRESENT ILLNESS

PHYSICAL EXAM

PROCEDURES

LAB

OUTSIDE RECORDS

ASSESSMENT

PLAN



AUTHORIZATION FOR RELEASE OF INFORMATION

DATE: 07/18/2024

I, Johnny Pate, 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:

<u>Individual's Name</u>	<u>Relationship</u>	<u>Phone Number</u>
<u>Dr. Vikas Bhushan</u>	<u>Oncologist</u>	<u>972-566-7790</u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>

*******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.

<u>Johnny Pate</u> (Signature of Patient or Responsible Party)	Verified by pdfFiller 07/18/2024 <u>03/04/1972</u> (Patient Date of Birth)
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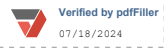


ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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: Johnny Pate

Signature: Johnny Pate 

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: 07/18/2024

(TUS) Use Only

Date acknowledgement received: _____ by: _____

-OR-

Reason not obtained:



Name: Johnny Pate Patient Birth date 03/04/1972

Today's date 07/18/2024

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 English

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 817-504-9269 HCW (circle type)

Email address: johnnypate@gmail.com

CIRCLE RACE

AFRICAN AMERICAN	HMONG	PACIFIC ISLANDER NOS
ASIAN INDIAN PAKISTANI SRI LANKAN	JAPANESE	POLYNESIAN NOS
<u>CAUCASIAN</u>	KAMPUCHEAN	SAMOAN
CHAMORRAN	CAMBODIAN	TAHITIAN
CHINESE	KOREAN	THAI
FIJI ISLANDER	LAOTIAN	THAI
FILIPINO	MELANESIAN NOS	TONGAN
GUAMANIAN NOS	MICRONESIAN NOS	VIETNAMESE
HAWAIIAN	NATIVE AMERICAN	UNKNOWN
	NEW GUINEAN	
HISPANIC	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS	

Options/Values were selected by HITECH Act and Texas State Tumor Registry.