



(Please Fill Out Completely)

Date _____

Home Phone# _____

Cell Phone # _____

Work Phone # _____

E-mail _____

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

Last Name _____ First _____ Middle _____

Address: _____

City _____ State _____ ZIP _____

Patient Employer _____ Occupation _____

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

Emergency Contact _____ Phone _____

Pharmacy Name / Location _____ Phone _____

Primary Care Doctor _____ Phone _____

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: _____

Pharmacy Name: _____	Address: _____	City: _____	Zip: _____
Pharmacy Phone #: _____		Pharmacy Fax #: _____	
Drug Allergies: _____		Reaction: _____	
Other Allergies: _____		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)

Family History

Name	Strength	Frequency	FAMILY HISTORY of kidney stones? ☐ Yes ☐ No
Daily use of aspirin? ☐ 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)

Social History

Year	Operation	Hospital	
			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 _____) # 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: _____ Occupation: _____

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

FOR DOCTORS ONLY:

CHIEF COMPLAINT

PRESENT ILLNESS

PHYSICAL EXAM

PROCEDURES

LAB

OUTSIDE RECORDS

ASSESSMENT

PLAN

Psychiatric--☐Neg
 Yes No
 anxiety ☐ ☐

11 System ROS
☐ All Negative



AUTHORIZATION FOR RELEASE OF INFORMATION

DATE: _____

I, _____, 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>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*******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.

(Signature of Patient or Responsible Party)

(Patient Date of Birth)



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: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Date: _____

(TUS) Use Only

Date acknowledgement received: _____ by: _____

-OR-

Reason not obtained:

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