

University Urologists, pg. 2

MEDICAL HISTORY: Please check any of the following conditions which **YOU** have had or presently have:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Neurologic disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperlipidemia / Choles. | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Inflammatory bowel | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Peptic Ulcer disease / Reflux | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Diverticular disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Valvular heart disease |
| <input type="checkbox"/> CVA (Stroke) TIA | <input type="checkbox"/> GERD | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Renal/Kidney disease | |
| <input type="checkbox"/> Chronic UTIs | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Attack | | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Other: _____ | | | |

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure

	Yr.		Yr.		Yr.	Females Only		Males Only	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Cystoscopy		<input type="checkbox"/> Kidney removed			Yr.		Yr.
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> ESWL		<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Bladder suspension		<input type="checkbox"/> Orchiectomy	
<input type="checkbox"/> CABG / Heart		<input type="checkbox"/> Gastric bypass		<input type="checkbox"/> Perc stone removal		<input type="checkbox"/> Breast biopsy		<input type="checkbox"/> Penile Prosthesis	
<input type="checkbox"/> Gall Bladder		<input type="checkbox"/> Hernia repair		<input type="checkbox"/> Kidney stone removal		<input type="checkbox"/> C-Section		<input type="checkbox"/> Prostate Biopsy	
<input type="checkbox"/> Colon surgery		<input type="checkbox"/> Hip replacement		<input type="checkbox"/> Ureteral Stents		<input type="checkbox"/> Abd Hyst		<input type="checkbox"/> Prostatectomy	
<input type="checkbox"/> Coronary stent		<input type="checkbox"/> Knee replacement		Other:		<input type="checkbox"/> Mastectomy		<input type="checkbox"/> TURP	
<input type="checkbox"/> Cataracts		<input type="checkbox"/> Tonsils		<input type="checkbox"/> Laser Stone Extraction		<input type="checkbox"/> Vaginal Sling		<input type="checkbox"/> Vasectomy	
				<input type="checkbox"/>		<input type="checkbox"/> TAH / BSO		<input type="checkbox"/> Prostate Radiation	
				<input type="checkbox"/>		<input type="checkbox"/> Tubal ligation		<input type="checkbox"/> Prostate CA Surgery	
						<input type="checkbox"/> Vaginal Hyst		<input type="checkbox"/> Prostate Non CA Surgery	
						<input type="checkbox"/> Vaginal Delivery			
						#			

TOBACCO:

Uses tobacco? Yes No Former Tobacco type: _____ Packs per day: _____ Number of years: _____

CAFFEINE: Yes No

Type: _____

Amount daily: _____

ALCOHOL: Yes No

Recovering

Urologic History:

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract infections? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or bladder stones? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in the urine? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinence (loss of urine) or bedwetting? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | X-rays of the kidneys? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous urologic tests or procedures? _____ |
| | | Other _____ |

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring health care provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assignment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductibles, co-insurances and co-pays. I understand that I am financially responsible for any charges not covered by my insurance and if I fail to give updated current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged \$35. If we determine your account should be placed with an outside collection agent or an attorney, you will be assessed an additional 30% of the balance due.

Signed: _____

Date: _____