

# Urology Associates

## Of Central Missouri

Legal Name \_\_\_\_\_ Name you go by \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ x

Sex: Male Female Marital Status (circle one): Single Married Divorced Widow

Date of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_

Referral Source (circle one)? Yellow Pages Friend/Relative Hospital \_\_\_\_\_ Insurance Internet

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician (if different from Referring Physician listed above):

Name \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance Policy Holder Information (if insurance is through spouse or parent)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

### Emergency Contact (friend/relative NOT living at your address)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Hm Phone \_\_\_\_\_ Cell Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ x

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

**ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Urology Associates of Central MO for any services furnished to me by my provider. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, responsible person(s) listed, or other healthcare providers assisting in my medical care.

**RECEIPT OF NOTICES OF PRIVACY PRACTICES:** I received or have waived my right to a copy of Urology Associates of Central Missouri's Notice of Privacy Practices.

**CONSENT TO TREATMENT:** I authorize Urology Associates of Central MO and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

**FINANCIAL AGREEMENT:** I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered.

\_\_\_\_\_  
**Signature of Patient** (For patients 17 yrs of age or younger, parent or guardian MUST sign.)

\_\_\_\_\_  
**Date**

# Urology Associates of Central Missouri New Patient Medical History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Today's Date: \_\_\_\_\_

Who referred you to Urology Associates? \_\_\_\_\_

Chief Complaint (What is the reason for your visit today?) \_\_\_\_\_

## History of Present Illness

Location of Problem: \_\_Flank \_\_Abdomen \_\_Pelvis \_\_Other \_\_\_\_\_

Severity of problem on a scale from 1-10 (with 10 being the most severe) 1 2 3 4 5 6 7 8 9 10

When did you 1<sup>st</sup> notice the problem? \_\_2 days ago \_\_2 wks ago \_\_1 mth \_\_Other \_\_\_\_\_

Does anything help or make the problem worse? \_\_Moving \_\_Standing Up \_\_Lying on side \_\_Other

How long does the problem last? \_\_30 min \_\_1 hr \_\_It is always there \_\_Other \_\_\_\_\_

Is anything else occurring at the same time? Yes No \_\_Nausea \_\_Rash \_\_Headaches \_\_Other

Is the problem constant or variable? \_\_Dull then Sharp \_\_Very sharp then leaves \_\_Always there \_\_Other

Does the problem interfere with your normal functions? Yes No If yes, please explain \_\_\_\_\_

### For provider use only:

<i>Hesitancy</i>	<i>Frequency in Day x _____</i>	<i>Nocturia</i>	<i>Gait</i>
<i>Intermittency</i>	<i>Frequency in Night x _____</i>	<i>Dysuria</i>	<i>Hx of Stones</i>
<i>Decreased Force of Stream</i>	<i>Urgency</i>	<i>Hematuria</i>	<i>Testicular Pain</i>
<i>Incomplete Empty</i>	<i>Incontinence, Stress (___pads/day)</i>	<i>Hx of UTI</i>	<i>Impotence</i>
<i>Double Void</i>	<i>Incontinence, Urge</i>	<i>Constipation</i>	<i>LBP / Sciatica</i>
			<i># of Answers 4+: L3-L5</i>

### Review of Systems: Please circle Y for Yes or N for No on ALL symptoms below.

<b>Constitutional Symptoms</b> Fever Y N Chills Y N Headache Y N Weight Loss Y N Weight Gain Y N Loss of Appetite Y N <b>Eyes/Ears</b> Blurred Vision Y N Double Vision Y N Hearing Loss Y N <b>Allergies: Seasonal</b> Y N <b>Neurological</b> Dizziness Y N	Memory Loss Y N <b>Endocrine</b> Excessive Thirst Y N <b>Gastrointestinal</b> Constipation Y N Diarrhea Y N Heartburn Y N Liver problems (hepatitis, cirrhosis) Y N Nausea/Vomiting Y N <b>Cardiovascular</b> Shortness of Breath Y N Chest Pain Y N Swelling of Feet Y N	<b>Integumentary</b> Skin rash Y N <b>Respiratory</b> Frequent Cough Y N Shortness of Breath Y N <b>Psychologic</b> Anxiety/Depression Y N <b>Musculoskeletal</b> Arm/Leg Weakness Y N Back Problems Y N Muscle Pain Y N
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### Medical History: Please check if you have experienced the following.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alzheimers Disease<br><input type="checkbox"/> Mental Health Condition<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Parkinson<br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Glaucoma (Open / Closed Angle)<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Sleep Apnea<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Lung Disease<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Bladder Cancer<br><input type="checkbox"/> Kidney Cancer<br><input type="checkbox"/> Prostate Cancer<br><input type="checkbox"/> Other Cancer, _____<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Urinary Infections (#/mth _____)<br><input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Kidney Stones<br><input type="checkbox"/> Inability to urinate at all<br><input type="checkbox"/> Heart Attack<br><input type="checkbox"/> Mitral Valve Prolapse<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Heart Stents<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> History of Blood Clots<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Other _____ |
|--|--|--|

**MALE PATIENTS – SKIP TO NEXT SECTION BELOW:**

Day of last menstrual period: \_\_\_\_\_  
Are you in menopause? \_\_\_yes \_\_\_no  
Number of pregnancy's? \_\_\_\_\_  
How many deliveries? \_\_\_\_\_ Were they vaginal or cesarean section? \_\_\_\_\_  
Date of last PAP \_\_\_\_\_ Date of last Mammography \_\_\_\_\_

**Past Surgeries: Please check if appropriate and list approximate year.**

- |  |  |
|--|--|
| <input type="checkbox"/> Cancer Surgery (type _____), Yr _____     | <input type="checkbox"/> Vasectomy, Yr _____                     |
| <input type="checkbox"/> Heart Surgery (type _____), Yr _____      | <input type="checkbox"/> Hysterectomy, Yr _____                  |
| <input type="checkbox"/> Transplant Surgery (type _____), Yr _____ | <input type="checkbox"/> Kidney removal, Yr _____                |
| <input type="checkbox"/> Artificial Heart Valve, Yr _____          | <input type="checkbox"/> Bladder Repair, Yr _____                |
| <input type="checkbox"/> Pacemaker, Yr _____                       | <input type="checkbox"/> Prostate Surgery (type _____), Yr _____ |
| <input type="checkbox"/> Knee Replacement, Yr _____                | <input type="checkbox"/> Stone Removal, Yr _____                 |
| <input type="checkbox"/> Hip Replacement, Yr _____                 | <input type="checkbox"/> Ureteral Stents, Yr _____               |
| <input type="checkbox"/> Hernia Repair, Yr _____                   | <input type="checkbox"/> Colon Surgery, Yr _____                 |
| <input type="checkbox"/> Back Surgery, Yr _____                    | <input type="checkbox"/> Cystoscopy, Yr _____                    |
| <input type="checkbox"/> Neck Surgery, Yr _____                    | <input type="checkbox"/> Other _____, Yr _____                   |
| <input type="checkbox"/> Appendectomy, Yr _____                    |  |
| <input type="checkbox"/> Gall Bladder, Yr _____                    |  |
| <input type="checkbox"/> Tubal Ligation, Yr _____                  |  |

**Family History: Place check if Parents, Grandparents, Brothers or Sisters have had the condition.**

- |  |  |
|--|--|
| <input type="checkbox"/> Cancer (type _____) | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Stones   |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Other _____     |

**Social History:**

Marital Status: married, single, divorced, widowed      How many children do you have? \_\_\_\_\_

Occupation (current or former): \_\_\_\_\_

Have you ever smoked? \_\_\_yes \_\_\_no  
If yes, how many packs per day? \_\_\_\_\_ for how many years? \_\_\_\_\_  
Do you continue to smoke? \_\_\_yes \_\_\_no If no, when did you quit? \_\_\_\_\_

Do you drink coffee or tea? \_\_\_yes \_\_\_no Number of cups per day \_\_\_\_\_

Do you drink cola drinks? \_\_\_yes \_\_\_no Number consumed per day \_\_\_\_\_

Do you use artificial sweetener? \_\_\_yes \_\_\_no

If one glass of wine or one can of beer equals one drink, how many drinks do you have per week? \_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

