Chief Complaint: What is the main reason for your visit today?

History of Present Illness
Location of the problem: □ Abdomen □ Back □ Groin □ Bladder
□ Other ____________________________

On a scale of 1-10, with 10 being the most severe,
What number best describes the problem? ____________________________

When did you first notice the problem? ____________________________

Does anything make the problem worse? □ Moving About □ Standing Up
□ Urinating □ Other ____________________________

Does anything help make the problem better? □ Change Posture □ Not Moving
□ Other ____________________________

Are there any treatments that your doctor would provide that are prohibited by your
religious beliefs? □ No □ Yes  If Yes, Please explain.

Have the symptoms changed over time? □ No □ Yes  If Yes, Please explain.

How long does the problem last? □ _____ Minutes □ _____ Hours □ Constant
□ Other ____________________________

Is anything occurring at the same time? □ No □ Yes  If Yes, Please explain.

Is the problem constant? □ No □ Yes  If not, please describe.

Does the problem interfere with your normal function? □ No □ Yes  If Yes, Please explain.

Past Medical, Social History, Family History
Allergies: □ No drug allergies □ Latex ____________________________

Surgery History: Type / Date  □ None

Have you had a blood transfusion? □ No □ Yes  Artificial heart valve? □ No □ Yes
Artificial joint? □ No □ Yes  Antibiotic prophylaxis required? □ No □ Yes
Cardiac stent? □ No □ Yes  Date ____________________________

Medical History: List any past or current illness and start date:  □ None

Family History: Condition, relationship (list any serious conditions in your imme-
diate family: e.g., diabetes, heart disease, kidney disease, kidney stones, prostate
cancer, etc.):  □ None

Medications/herbs/supplements: name, dosage, instructions —
(e.g., Flomax 0.4mg once daily) □ None
Name ________________________________  
Account # ________________________________  

**Medical History Form**

**Medications/herbs-supplements (continued):**

Any: Hearing Loss, Stuffy Nose, or Sore Throat? □ No □ Yes

Any: Chest Pain, Swollen Ankles, or Irregular Heart Beats? □ No □ Yes

Any: Shortness of Breath, Wheezing, or Chronic Cough? □ No □ Yes

Any: Stomach Pain, Nausea/Vomiting, or Bowel Changes? □ No □ Yes

Any: Back Pain, Neck Pain, or Sore Muscles? □ No □ Yes

Any: Rash, Itching, or History of Skin Cancer? □ No □ Yes

Any: Swollen Glands, Bleeding, or Transfusions? □ No □ Yes

**All Patients:**

It is the responsibility of the patient to notify this office of pre-admission and/or second opinion requirements of their insurance company at the time of scheduling hospital admissions or surgery. I hereby authorize the release of any medical information pertinent to my care to my referring physician/family physician and insurance companies and accept responsibility for payment of all medical/surgical fees. I also authorize payment of insurance benefits to Associated Urologists of North Carolina, PA, except when the amount has been paid in full by me.

Signed ________________________________  
Print name ________________________________  
Date ________________________________

**Medicare Patients:**

I request that payment under the Medicare Insurance Program be made directly to Associated Urologists of North Carolina, PA, on any bills for service furnished by their physicians during my lifetime. I understand that I may be held responsible for a portion of these bills after Medicare has paid the provider, or for any charges that Medicare does not cover.

Signed ________________________________  
Print name ________________________________  
Date ________________________________

**Review of Symptoms:**

Within the past six months, any problems with any of the following? If, yes, please explain. □ None

Any: Fever, chills, or weight loss? □ No □ Yes

Any: Blurry vision, Double Vision, or Cataracts? □ No □ Yes

Date of last physical examination ________________________________

What is your Height? _____ ft. _____ in.  What is your Weight? _____ lbs.

Smoking History □ Never Smoked □ Former Smoker □ Current Smoker

□ Current Some Day Smoker    □ Started Smoking ________________

□ Stopped Smoking ___________ Amt: □ Day □ Week ________________

□ Chew □ Dip tobacco  □ Amt: □ Day □ Week ________________

Do you drink alcohol? □ Yes □ Not anymore □ Never

Drinks per □ Day □ Week □ Month □ Year ________________________________

Type: □ Beer □ Liquor □ Wine

□ Present Or □ Prior Drinking Habits: □ Social □ Light

□ Moderate □ Excessive

□ Quit (year) ________________ Drank how long? ___________ Years

How much caffeine do you consume daily? Cups coffee ___________, Cups tea ___________

# Sodas __________ # Power drinks __________ Other ___________

Type and amt. chocolate __________

Any: Hearing Loss, Stuffy Nose, or Sore Throat? □ No □ Yes

Any: Chest Pain, Swollen Ankles, or Irregular Heart Beats? □ No □ Yes

Any: Shortness of Breath, Wheezing, or Chronic Cough? □ No □ Yes

Any: Stomach Pain, Nausea/Vomiting, or Bowel Changes? □ No □ Yes

Any: Back Pain, Neck Pain, or Sore Muscles? □ No □ Yes

Any: Rash, Itching, or History of Skin Cancer? □ No □ Yes

Any: Swollen Glands, Bleeding, or Transfusions? □ No □ Yes

Any: Hearing Loss, Stuffy Nose, or Sore Throat? □ No □ Yes

Any: Chest Pain, Swollen Ankles, or Irregular Heart Beats? □ No □ Yes

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Any: Stomach Pain, Nausea/Vomiting, or Bowel Changes? □ No □ Yes

Any: Back Pain, Neck Pain, or Sore Muscles? □ No □ Yes

Any: Rash, Itching, or History of Skin Cancer? □ No □ Yes

Any: Swollen Glands, Bleeding, or Transfusions? □ No □ Yes

**Medical History Form**

Name ________________________________  
Account # ________________________________  

**Medications/herbs-supplements (continued):**

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Any: Chest Pain, Swollen Ankles, or Irregular Heart Beats? □ No □ Yes

Any: Shortness of Breath, Wheezing, or Chronic Cough? □ No □ Yes

Any: Stomach Pain, Nausea/Vomiting, or Bowel Changes? □ No □ Yes

Any: Back Pain, Neck Pain, or Sore Muscles? □ No □ Yes

Any: Rash, Itching, or History of Skin Cancer? □ No □ Yes

Any: Swollen Glands, Bleeding, or Transfusions? □ No □ Yes

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