

The Florida Urology Center

2019 Patient Information Update

Date: _____ **Acct#:** _____ **Dr. M P H G**

Name: _____ **SS#:** _____ **DOB:** _____ **Age:** _____

Address: _____
Street City, State Zip Code

Primary Phone (_____) _____ - _____ Cell Secondary Phone (_____) Cell

Patient
Initials

I authorize messages with medical information to be left at the above number(s)? _____

Others that we may speak with about your health care: _____

Employer: _____ **Phone:** _____

Who is your Family Doctor?: _____ **Phone:** _____

What pharmacy do you use?: _____ **Phone:** _____

What lab do you use?: _____ **Phone:** _____

Insurance: **Primary** _____ **Secondary** _____

ASSIGNMENT OF BENEFITS : By signing below, I authorize the release of all medical information to my insurance company and request that payment of my insurance benefits be sent directly to The Florida Urology Center (unless full payment is made at the time of service).

CONSENT FOR TREATMENT: By signing below, I authorize treatment by the Florida Urology Center's physicians and their staff.

MEDICAL RECORDS CONSENT: By signing below I authorize The Florida Urology Center's physicians and staff to obtain my medical records for my treatment.

CONTACT: By signing below, I authorize all of the phone numbers I have provided (including my mobile number) to be used to communicate with me regarding my treatment, billing or services referred.

Signature _____ **Date** _____

ALLERGY HISTORY				List any RECENT SURGERY
YES		YES		
Aspirin		Tetracycline		
Codeine		Cipro		
Morphine		Latex		
Mycins		Iodine		
Penicillin		Other:		
Sulfa				

LIST ALL MEDICATIONS: PRESCRIPTION AND OVER THE COUNTER , Or provide written list			
Medication name	Dosage/Strength	Frequency:how oft	Taken orally?

↓ **2019** ↓
****CONTINUED ON BACK****

The Florida Urology Center 2019

Check all that apply

<u>CONSTITUTIONAL</u>	YES	<u>RESPIRATORY</u>	YES	<u>HEMATOLOGIC/LYMPH</u>	YES
Weight Loss	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	Coughing Blood	<input type="checkbox"/>	Gums Bleed Easily	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Enlarged Glands	<input type="checkbox"/>
<u>EYES</u>		Chills	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>
Glasses/Contacts	<input type="checkbox"/>	<u>GASTROINTESTINAL</u>		<u>MUSCULOSKELETAL</u>	
Eye Pain	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	Change in B.M.'s	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>
<u>EAR, NOSE, THROAT</u>		Diarrhea	<input type="checkbox"/>	<u>SKIN</u>	
Difficulty Hearing	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Rash/Sores	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Lesions	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Itching/Burning	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<u>NEUROLOGICAL</u>	
Nasal Stuffiness	<input type="checkbox"/>	<u>GENITOURINARY</u>		Seizures	<input type="checkbox"/>
Frequent Sore Throat	<input type="checkbox"/>	Pain Urinating	<input type="checkbox"/>	Weakness/Paralysis	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	Burning	<input type="checkbox"/>	Numbness	<input type="checkbox"/>
<u>CARDIOVASCULAR</u>		Frequency	<input type="checkbox"/>	Tremors	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	Nighttime	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<u>ALLERGIC/IMMUNOLOGIC</u>	
Palpitations	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	Hay Fever/Asthma	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	History of Kidney Stones	<input type="checkbox"/>	Hives/Eczema	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	History of Sexually	<input type="checkbox"/>	<u>PSYCHIATRIC</u>	
Shortness of Breath	<input type="checkbox"/>	Transmitted Disease	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>
Difficulty Lying Flat	<input type="checkbox"/>	Abnormal Discharge	<input type="checkbox"/>	Mood Swings/Difficult Sleep	<input type="checkbox"/>
Swelling Ankles/Other	<input type="checkbox"/>	<u>ENDOCRINE</u>		<u>FEMALE ONLY:</u>	
<u>OTHER</u>		Loss of Hair	<input type="checkbox"/>	Age of Onset of Periods	_____
Cancer: _____	<input type="checkbox"/>	Heat/Cold Intolerance	<input type="checkbox"/>	Age of Onset Menopause	_____
Diabetes: _NonInsulin_Insulin	<input type="checkbox"/>	Change in Nails	<input type="checkbox"/>	Are Periods Regular?	Y/N

HABITS	YES
Exercise Adequately	<input type="checkbox"/>
Coffee () cups per day	<input type="checkbox"/>
Alcoholic Beverages() per day	<input type="checkbox"/>
Cigarettes/Cigars() per day	<input type="checkbox"/>
Sex-Entirely Satisfactory	<input type="checkbox"/>

FAMILY HISTORY/PT.RELATIONSHIP
Cancer
Diabetes
Heart Trouble
High Blood Pressure
Stroke
Kidney Stones

X-RAY HISTORY/DATE	YES
Chest	<input type="checkbox"/>
CT Scan	<input type="checkbox"/>
Bone Scan	<input type="checkbox"/>
IVP	<input type="checkbox"/>
KUB	<input type="checkbox"/>
MRI	<input type="checkbox"/>

What is your current weight? _____

What is your height? _____