Florida Urology Center

www.floridaurology.com

Bert M. Morrow, M.D.
Greg A. Parr, M.D.
Dane K. Hermansen, M.D.
Jay C. Guido, M.D.
Frank S. Melograna, M.D.
John K. Burgers, M.D.
Board Certified Urologists

2024 Patient Information Update

Date:	Account #			Doctor: M P H G FM B	
Name:		SS#		DOB:	Age
Address:		City:		State:	Zip:
Primary Phone:	( ) - Cell ❒		Secondary Phone:	( ) -	Cell ❒

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

Others that F.U.C. may speak with about your health care: _____

Employer:	Phone:
Family Doctor:	Phone:
Your Pharmacy:	Phone:
What Lab do you use?	

Insurance: Primary _____

Insurance: 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 Record Consent: By signing below, I authorize the Florida Urology Center's physicians and staff to obtain my medical records for treatment.

HIPPA: By signing below, I acknowledge that I have received a copy of the Notice of Health Information Practices.

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	YES		YES	LIST ANY RECENT SURGERY
Aspirin		Tetracycline		
Codeine		Cipro		
Morphine		Latex		
Mycins		Iodine		
Penicillin		Sulfa		
Other:				

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2024 Review of Symptoms | Check All That Apply

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

HABITS	YES	FAMILY HISTORY – PATIENT RELATIONSHIP	YES
Exercise Adequately		Cancer	
Coffee ( ) Cups per day		Diabetes	
Alcoholic Beverages ( ) per day		Heart Trouble	
Cigarettes / Cigars ( ) per day		High Blood Pressure	
Sex-Entirely Satisfactory		Stroke	
		Kidney Stones	

X-RAY HISTORY / DATE	YES	OTHER	
Chest		What is your current weight?	Lbs.
CT Scan			
Bone Scan		What is your height?	Ft. In.
IVP			
KUB			
MRI			

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