Urology Associates
of SENC, P.A.

UROLOGY ASSOCIATES OF SENC,PA **PROVIDER**_____

PATIENT INFORMATION: **CHART #**_____

Patient Name (Last, First, Middle)_____

Patient Mailing Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____ Other_____

Sex: Male ☐ Female ☐ Date of Birth_____ SS#_____

Martial Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Race: White ☐ Asian ☐ African-American ☐ Hispanic ☐

Ethnicity: Hispanic ☐ Latino ☐ NonHispanic or Latino ☐

Language: English ☐ French ☐ Spanish ☐

Employer _____ Phone _____

Person to Contact In Case Of Emergency (List Two)

Name _____ Phone(H)_____ (W)_____

Name _____ Phone(H)_____ (W)_____

If Patient is under 18 years of age:
Note: Guarantor must be the person who signs the consent for the patient to receive treatment today.

Please present your insurance card/cards to the receptionist.
If either insurance is not in the patient's name, we cannot file charges to the insurance without the following information

Guarantor Name _____ Relationship to Patient_____

Guarantor Address _____

Guarantor Phone _____ Guarantor SS #_____

DOCTOR INFORMATION:

Referring Doctor:_____ **Phone #** _____

Primary Care Doctor_____ **Phone #** _____

INSURANCE INFORMATION:

Insured's Name _____ **Insured's DOB**_____

Insured's Employer _____ **Insured's SS #**_____

Work Related Injury or Illness YES ☐ NO ☐ Date of Injury _____

EMAIL ADDRESS:_____

SIGNATURE _____ DATE _____

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Please check the ☐ for all that apply for your appropriate health information:

Name_____ Today's Date_____

Date of Birth_____ Primary MD_____

Allergies:

☐ None ☐ IV Contrast ☐ Iodine ☐ Aspirin ☐ Codeine ☐ Demerol
☐ Penicillin ☐ SulfaJBactrim ☐ Cipro ☐ Macrobid ☐ Latex ☐ Morphine

Past Medical Illinesses:

☐ BPH ☐ None ☐ Low Testosterone ☐ Kidney Stones
☐ Kidney Cancer ☐ Prostate Cancer ☐ Recurrent UTI's ☐ Prostate Infections
☐ Urinary Incontinence ☐ Kidney Failure ☐ Heart Attack ☐ Heart Failure
☐ Diabetes ☐ Hypertension ☐ Stroke ☐ High Cholesterol
☐ Irregular Heart Beat ☐ Atrial Fibrillation
☐ Emphysema ☐ Asthma ☐ Anemia ☐ Migraines
☐ Depression ☐ Skin Cancer ☐ Hiatal Hernia ☐ Back Pain
☐ Sleep Apnea ☐ Stomach Ulcers ☐ Thyroid Disease ☐ HIV/Aids
☐ TB (Tuberculosis) ☐ Breast Cancer ☐ Reflux ☐ Colon Cancer
☐ Glaucoma ☐ Irritable Bowel ☐ Colon Polyps ☐ Seizures
☐ Gout ☐ Rheumatic Fever ☐ Other_____
☐ Sexually Transmitted Disease

Previous Surgeries: PLEASE INCLUDE DATE/YEAR

☐ Colon Resection_____ ☐ Groin Hernia_____ ☐ Joint Replacement_____
☐ Colonoscopy_____ ☐ Tonsils_____ ☐ Breast Removal for Breast
☐ Hiatal Hernia_____ ☐ Ovary_____ Cancer_____
☐ C-Section_____ ☐ Thyroid_____ ☐ Tubal Ligation_____
☐ TURP_____ ☐ Laser Prostate_____ ☐ Prostate Removal_____
☐ Heart Bypass_____ ☐ Kidney Stones_____ ☐ Uterus Removal_____
☐ Kidney Removal_____ ☐ Appendix_____ ☐ Gallbladder Removal____
Other_____

Social History:

Tobacco: ☐ I have never used tobacco products ☐ I use tobacco products

How many packs per day_____ ☐ I quit using tobacco procducts

Alcohol: ☐ Never ☐ Rarely ☐ Less than 2 days/week ☐ Daily ☐ I quit using alcohol

Family History: ☐ Prostate Cancer ☐ Kidney Cancer ☐ Kidney Stones ☐ Bladder Cancer

☐ I DOT NOT HAVE A FAMILY HISTORY OF URINARY CANCERS

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Name____ **Date of Birth** ______________

PHARMACY NAME AND LOCATION:

____

Medication Name: Example - Aspirin	**Dosage:** 81 mg	**Number of times taken per day:** Daily

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Urology Associates

PLEASE CIRCLE YES OR NO FOR ALL THAT APPLY

PATIENT NAME _____

Review of Systems	Yes	No
General:		
Weight Gain	○	○
Weight Loss	○	○
Appetitle Loss	○	○
Chills	○	○
Fever	○	○
Weight Loss > 10lbs	○	○
Skin:		
Dryness	○	○
Hives	○	○
Itching	○	○
Rash	○	○
HEENT:		
Blurred Vision	○	○
Headache	○	○
Eye Pain	○	○
Visual Loss	○	○
Hearing Loss	○	○
Ear Pain	○	○
Nose Bleed	○	○
Sinus Pain	○	○
Sore Throat	○	○
Voice Changes	○	○
Respiratory:		
Cough	○	○
Decreased Exercise Tolerance	○	○
Difficulty Breathing	○	○
Shortness of breath	○	○
Wheezing	○	○
Breast:		
Breast Mass	○	○
Breast Pain	○	○
Breast Swelling	○	○
Nipple Discharge	○	○
Nipple Pain	○	○
Skin Changes	○	○

Review of Systems	Yes	No
Cardiovascular:		
Chest Pain	○	○
Edema	○	○
Palpitations	○	○
Shortness of Breath	○	○
Swelling of Legs	○	○
Gastrointestinal:		
Hemorrhoids	○	○
Abdominal Pain	○	○
Change in Bowel Habits	○	○
Indigestion	○	○
Nausea	○	○
Vomiting	○	○
Genitourinary:		
Change in Urinary Stream	○	○
Burning when you urinate	○	○
Frequency	○	○
Blood in the urine	○	○
Incontinence	○	○
Urgency	○	○
Impotence (Men)	○	○
Nighttime urinating	○	○
Musculoskeletal:		
Bone pain	○	○
Neurological:		
Trouble walking	○	○
Headaches	○	○
Seizures	○	○
Psychiatric:		
Anxiety	○	○
Depression	○	○
Endocrine:		
Sexual Dysfunction	○	○
Hematology:		
Easy Brusing	○	○