

# UROLOGY AND UROLOGIC SURGERY

Patient History Form (Please Print) Today's Date: \_\_\_\_\_ 1 of 2

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Email address: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Guarantor's Information:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_ DOB \_\_\_\_\_

## Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

## Physician Information:

Referred by: \_\_\_\_\_ Phone# \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

What is the main reason for your visit? (Describe your problem in detail)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## Allergies and Medications

List your current allergies and reactions:

List all your current medications and dosage: (you may provide a list if available)

Provide the name, address and phone number of your preferred pharmacies.

## Past Medical and Surgical History

List any personal illnesses/diagnosis/disease and when they occurred: Example (High blood pressure-11/2013)

List any procedures/surgeries you have had. PLEASE PROVIDE APPROXIMATE DATE OF PROCEDURE/SURGERY:

## Family History

Circle any illnesses in your immediate family: Include the relationship to you :

Prostate Cancer _____	Bladder Cancer _____	Kidney Cancer _____	Breast Cancer _____
Diabetes _____	Heart Problems _____	High Blood Pressure _____	Uterine Cancer _____
Kidney Failure _____	Infertility _____	Lung Cancer _____	Skin Cancer _____
Tuberculosis _____	Parkinson's Disease _____	Kidney Stones _____	Thyroid Problem _____
Stroke _____	Recurrent UTI _____	Enuresis _____	Other: _____

**Social History (Circle answer)**

Marital Status: Married Single Divorced Widowed Separated Annulled Unknown

Smoking Status: Current Every Day Smoker Current Some Day Smoker Former Smoker  
Never Smoked Smoker/status unknown Unknown if ever smoked

If ever Smoked answer the following:

How much do you/did you smoke? \_\_\_\_\_ For how many years did/have you smoked? \_\_\_\_\_

Do you use smokeless tobacco? Yes or No Do you use recreational drugs? Yes or No

Do you Drink Alcohol? Yes Not Any More Never Drank

Type(s) of alcohol consumed: Beer Wine Alcohol Drinking Habit: Social Light Moderate Excessive

How many caffeinated drinks do you have each day? 0 1 2 3 4+ Have you had a blood transfusion? yes No

Race: American Indian/Alaska Native Black/ African American Eskimo Pacific Islander White  
Asian Decline to specify

Language: English Chinese French German Italian Japanese Portuguese Russian Spanish Other

Ethnicity: Not Hispanic or Latino Hispanic Decline to specify Unknown

**Review of Systems (Circle all issues that apply in the last month)**

- General: Fatigue Chills Fever Weight gain >10 Weight loss <10
- Skin: Nail Changes Rash
- ENT: Blurry Vision Cataracts Glaucoma Sore Throat Dry mouth
- Neck: Neck Pain Swollen Glands
- Respiratory: Shortness of breath Wheezing Cough Hemoptysis
- Cardiovascular: Chest pain Palpitations Swollen ankles Tachycardia
- Gastrointestinal: Abdominal pain Nausea Vomiting Constipation Blood in stool Diarrhea
- Musculoskeletal: Sore muscles Muscle weakness Joint pain Joint swelling Joint stiffness
- Breast: Breast mass Breast pain Nipple discharge Skin changes
- Neurological: Numbness Dizziness Headaches Seizures Paralysis
- Psychiatric: Anxiety Depression Hallucinations Suicidal thoughts
- Endocrine: Appetite changes Cold intolerance Increased thirst
- Hematology: Swollen glands Abnormal bleeding Transfusion history Easy bruising  
Use of blood thinners

.....  
Authorization: I hereby authorize the office to furnish information to insurance carriers this illness/accident and service rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance.

X \_\_\_\_\_  
Patient Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

JERRY H. ROSENBERG AND STEPHANIE E. HUGHES, MD

Urology and Urologic Surgery

4224 Houma Boulevard, Suite 260  
Metairie, Louisiana 70006  
P(504)887-5555 F(504)888-5031

67186 Industry Lane, Suite B  
Covington, Louisiana 70433  
P(985)892-9088 F(985)892-8594

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from the third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time. I am aware that I can contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations; I also understand you are not required to agree to my request restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Signature of Patient or  
Legally Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

.....  
OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented.

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

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**RELEASE OF PERSONAL MEDICAL INFORMATION**

I, \_\_\_\_\_ consent to the above office releasing my  
medical information to the following individual:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Date of Birth

\*\*\*\*\*

**OFFICE USE ONLY**

\_\_\_\_\_  
Office Staff Initials

\_\_\_\_\_  
Date