UROLOGY AND UROLOGIC SURGERY

Patient History Form (Please Print) Today's Date:_____

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 reaction:

_____

_____

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

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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 Couch 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)892-8088 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

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OFFICE USE ONLY

_____ _____
Office Staff Initials Date