GLP-WESTERN NEW YORK UROLOGY ASSOCIATES

Patient Information - Page 1

A. PATIENT INFORMATION:

Name _____ Primary Physician_____
Last First M.I.

OB/GYN Physician_____

Nickname/preferred first name_____

Address _____
Street City Zip

Birth date _____ SS #: _____ Home Phone _____ Work Phone _____

Sex: M F Marital Status: S M W D Student: Yes/No If yes, Full-Time or Part-Time

Home Phone_____ Work phone _____ Cell _____ E- mail _____

Western New York Urology Associates may use the contact information above to confirm and/or communicate with you.

Retired: Yes/No Retirement Date _____ Retired from _____

Employer _____ Occupation _____

Spouse's name _____ Birth date_____

Spouse's Employer _____ Occupation _____

Pharmacy Name/Location _____

Emergency Contact _____ Address _____ Phone _____

Relationship to patient: _____

B. RESPONSIBLE PARTY: ____ (Check if same as patient information and skip to item C.)

Name _____
Last First M.I.

Address _____
Street City Zip

Birth date _____ SS# _____ Home Phone _____ Work Phone_____

C. REFERRAL SOURCE: ____ Primary Physician ____ Personal Referral ____Other Physician_____

____ Internet ____ Local Edge ____ Verizon ____ Other (please specify) _____

D. INSURANCE INFORMATION:

Primary Insurance _____ Insurance ID # _____ Group _____

Subscriber Name (skip if same as responsible party) _____
Person that holds the policy

Secondary Insurance Name and Address _____

Subscriber's Name _____ Date of Birth _____

Subscriber's SS# _____ Subscriber's Employer _____ Plan Name _____

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Medical History – Page 2

Patient Name _____ Height_____ Weight _____

RACE (Optional): Caucasian_____ African American_____ Hispanic_____ Native American_____ Alaskan Native _____ Asian_____

ETHNICITY (Optional)_____ Primary Language _____

If English is not your primary language, do you need assistance with translation? YES NO

ALLERGIES ____ None List any medicines, foods, or other substances to which you are ALLERGIC:

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Do you have an allergy to latex? YES NO

CURRENT DAILY MEDICATIONS: Please list any medications, including non-prescription drugs and birth control pills that you have taken in the last three months.

Medication	Dose/Frequency	Prescribed by	Reason for Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Smoker YES NO Former smoker YES NO

If presently smoking or a former smoker: Packs per day: _____ Years smoking history: _____

Alcohol YES NO Former alcohol use YES NO

Recreational drugs YES NO Former recreational drug use YES NO

Have you ever been hospitalized for any type of surgery? YES NO If yes, please list:

_____

Have you ever been hospitalized for any condition that did NOT require surgery? YES NO If yes, please list:

_____

Are you able to stand, weight bear, and transfer from a chair to an exam table? YES NO

No restrictions Limited Walker Wheelchair

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Medical History – Page 3

Do you have, or have you ever had any of the following conditions or problems?

1. Diabetes YES NO

2. Cancer YES NO

   If yes, site of cancer _____ Year diagnosed _____

   Are you currently receiving radiation or chemotherapy treatment? YES NO

3. Are you receiving treatment for any other type of abnormal growth or tumor? YES NO

4. Bladder disorders:

   Is it hard to make it to the bathroom? YES NO

   Are you occasionally leaking urine? YES NO

   Do you sometimes leak urine while sneezing or coughing? YES NO

5. Bowel disorders:

   Do you have to push on the skin around your anus or vagina to get stool to pass? YES NO

6. Pelvic floor support disorders:

   Do you have a feeling of heaviness or fullness, as though something is falling out of your vagina or rectum? YES NO

   Are you experiencing pressure or a bulging sensation in your lower abdomen or pelvis, especially after standing for long periods of time? YES NO

7. Are you receiving treatment for any other type of abnormal growth or tumor? YES NO

8. Kidney or bladder problems including stones, infections, etc.? YES NO

9. Thyroid problems? YES NO

10. Stomach or intestinal problems; including ulcers or colitis? YES NO

11. Blood disorders; including blood clots, anemia or abnormal bleeding? YES NO

12. Liver problems; including hepatitis, contact with a person with hepatitis, yellow jaundice, yellow skin or eyes, or cirrhosis? YES NO

13. Neurologic problems; seizures, multiple sclerosis, Parkinsons, stroke, or problems with your balance, vision, or hearing? YES NO

    If yes, please specify: _____

14. Heart problems; heart murmur, high blood pressure, chest pain, shortness of breath, heart attack, angina, or rheumatic fever? YES NO

    If yes, please specify: _____

15. Do you have an automatic defibrillator? YES NO

16. Have you had a joint replacement? YES NO

17. Lung problems; asthma, emphysema, bronchitis, pneumonia, or exposure to tuberculosis? YES NO

    If yes, please specify: _____

18. Do you have sleep apnea? YES NO
    If yes, do you use a C-PAP machine? YES NO

19. Do you have any medical condition not mentioned above? If so, explain below. YES NO

_____

_____

_____

20. Is there a family history of:

	YES	NO	FAMILY MEMBER
Tuberculosis	____	____	_____
Cancer (specify site)	____	____	_____
Diabetes	____	____	_____
High blood pressure	____	____	_____
Heart disease	____	____	_____

21. Do you have children? ____ ____ How many? _____

22. Is this visit for a Workers' Compensation claim or a work related injury? YES NO
    If yes, please ask receptionist for a Workers' Compensation form.

23. If a Vietnam veteran, did you have exposure to Agent Orange? YES NO

24. If you are over 50 years of age, have you had a colonoscopy? YES NO
    If yes, when was this done?_____

25. If you are female, is there any chance you may be pregnant? YES NO

26. Are you nursing at this time? YES NO

27. Have you had a Pap smear in the last year? YES NO

28. If you are female and over 50 years of age, have you had
    mammography in the past 27 months? YES NO

29. If you are female and over 60 years of age, have you had a bone density scan? YES NO
    If yes, when was this done?_____

Other relevant information and/or concerns you would like the doctor to be aware of, including any questions you would like answered: _____

_____

What brings you to our office today?_____

_____

WESTERN NEW YORK UROLOGY ASSOCIATES
MEDICAL HISTORY CONSENT

Please sign in the five areas as indicated.

CONFIRMATION OF MEDICAL HISTORY
I have read the questions on pages 1, 2, and 3 and have completed them truthfully and to the best of my ability.

_____ _____ _____
Required Signature of Patient and/or Responsible Party Date

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR MEDICARE/INSURANCE BILLING
I request that payment of authorized Medicare and/or other insurance company benefits be made on my behalf for any services furnished me by Western New York Urology, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and/or other insurance companies and their agents any information needed to determine these benefits or benefits for related services.

_____ _____ _____
Required Signature of Patient and/or Responsible Party Date

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS
I hereby consent to the use and disclosure of my Protected Health Information by Western New York Urology for purposes of treatment, payment and/or healthcare operations. I hereby consent to the use and disclosure of my Protected Health Information by Western New York Urology to arrange for treatment by another provider or for the referral of another provider or entity, including a Business Associate of Western New York Urology and for business operations of Western New York Urology, or its related treatment entities.

I understand that my signature on the consent is required in order for me to receive care from the Physician Practice and that the Physician Practice may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for its treatment, payment and health care operations.

_____ _____
Required Signature of Patient and/or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I understand that further information on the Physician Practice's uses and disclosures of my Protected Health Information is included in the Physician Practice's Notice of Privacy Practices. I acknowledge receipt of Western New York Urology's Notice of Privacy Practices.

_____ _____
Required Signature of Patient and/or Responsible Party Date

CONSENT FOR MEDICAL RECORD PHOTOGRAPHY
I hereby consent to having my photograph taken as part of my medical record. The taking of the photography will assist Western New York Urology, in the identification of patients and will assist in eliminating record misidentification. This photograph will be part of my medical record and shall remain strictly confidential to the same extent as my patient records remain confidential under Western New York Urology's policy and New York State Law.

_____ _____
Required Signature of Patient and/or Responsible Party Date

WESTERN NEW YORK UROLOGY ASSOCIATES

Review of Systems

Do you currently have any problems related to the following systems? Circle Yes or No

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other _____

Allergies/Immunologic

Hay Fever Y N
Drug allergies Y N
Other_____

Endocrine

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Eyes

Blurred vision Y N
Double vision Y N
Pain Y N
Other_____

Ears/Nose/Throat/Mouth

Ear infection Y N
Sore throat Y N
Sinus problems Y N
Other _____

Cardiovascular

Chest pain Y N
Varicose veins Y N
High blood pressure Y N
Other _____

Respiratory

Wheezing Y N
Frequent cough Y N
Short of breath Y N
Other_____

Gastrointestinal

Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other _____

Genitourinary

Burning w/ urination Y N
Weak stream Y N
Get up at night Y N
Daytime frequency Y N
Retention of urine Y N
Kidney stone pains Y N
Erection problems Y N
Other _____

Neurological

Tremors Y N
Dizzy Spells Y N
Numb/tingling Y N
Other _____

Integumentary

Skin rash Y N
Persistent itch Y N
Infections Y N
Other _____

Musculoskeletal

Joint pain Y N
Neck pain Y N
Back pain Y N
Other_____

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Lymph node enlargement Y N
Other _____

This form has been completed by the patient. **Date** _____