The Florida Urology Center

2018 Patient Information Update

Date: _____ **Acct#:** _____ **Dr. M P H G**

Name:_____ **SS#:**_____ **DOB:**_____ **Age:** ___

Address: _____

Street City, State Zip Code

Primary Phone (_____) _____-_____ ☐ Cell Secondary Phone (_____) _____-_____ ☐ Cell

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

Others that we may speak with about your health care:_____

Employer: _____ Phone: _____

Who is your Family Doctor?: _____ Phone: _____

What pharmacy do you use?: _____ Phone: _____

What lab do you use?: _____ Phone: _____

Insurance: Primary _____ **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 RECORDS CONSENT: By signing below I authorize The Florida Urology Center's physicians and staff to obtain my medical records for my treatment.

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		Other:		
Sulfa				

LIST ALL MEDICATIONS: PRESCRIPTION AND OVER THE COUNTER , Or provide written list			
Medication name	Dosage/Strength	Frequency:how often	Taken orally?

The Florida Urology Center 2018

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	☐	**PSYCHIATRIC**	
Shortness of Breath	☐	Transmitted Disease	☐	Anxiety/Depression	☐
Difficulty Lying Flat	☐	Abnormal Discharge	☐	Mood Swings/Difficult Sleep	☐
Swelling Ankles/Other		**ENDOCRINE**	☐	**FEMALE ONLY:**	☐
OTHER		Loss of Hair	☐	Age of Onset of Periods	_____
Cancer:_____	☐	Heat/Cold Intolerance	☐	Age of Onset Menopause	_____
Diabetes: _NonInuslin _Insulin	☐	Change in Nails	☐	Are Periods Regular?	Y/N

HABITS	YES
Exercise Adequately	
Coffee ( )cups per day	
Alcoholic Beverages( )per day	
Cigarettes/Cigars( )per day	
Sex-Entirely Satisfactory	

FAMILY HISTORY/PT.RELATIONSHIP	YES
Cancer	
Diabetes	
Heart Trouble	
High Blood Pressure	
Stroke	
Kidney Stones	

X-RAY HISTORY/DATE	YES
Chest	
CT Scan	
Bone Scan	
IVP	
KUB	
MRI	

What is your current weight? _____lbs

What is your height? _____