UROLOGY ASSOCIATES OF HOUSTON, P.A.

Please bring insurance cards, a picture I.D., any lab test, diagnostic test report, films, and completed paperwork to your appointment. **DO NOT MAIL** PAPERS TO OFFICE, BRING THEM WITH YOU TO THE APPOINTMENT.

Appointment date: ___________________
Appointment Time: ___________________

******Please arrive 30 minutes prior to your appointment******
Arrive by : _________________

Your appointment is at our:

CLEAR LAKE
250 BLOSSOM #220
WEBSTER TX 77598
281-332-0202

MEMORIAL SOUTHEAST
11914 ASTORIA BLVD STE 520
HOUSTON TX 77089
281-481-2804

PEARLAND
10905 MEMORIAL HERMANN DR #211
PEARLAND TX 77584
281-332-0202 / 281-481-2804

To better treat you, please provide us with your pharmacy and physician name that you will want us to correspond with. Please return this page at your next visit.

PHARMACY Name: ____
Address: ____
Phone: ___________________________________
Fax: ___________________________________

PRIMARY CARE PHYSICIAN FULL NAME

Primary or Referring Doctor Name: ________________________________
Address: ____
Phone: ________________________________
Fax: ________________________________

UROLOGY ASSOCIATES OF HOUSTON, P.A.

Receipt of notice of Privacy Practices
Written Acknowledgement Form

I, ________________________________ Date of Birth ____________ Account # ____________

I acknowledge that I have received a copy of UROLOGY ASSOCIATES OF HOUSTON, P.A.'s Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

______________________________ ______________________________ ______________________
SIGNATURE OF PATIENT / PARENT / GUARDIAN RELATIONSHIP TO PATIENT DATE

***You may notify us below regarding your request for confidential communications & restrictions*:**
(Please mark YES, NO, OR N/A)

1. **Please indicate where we may contact you by phone (at the numbers listed in your patient information).**

   Home: ___yes ___no ___N/A **Work**: ___ yes ___no ___N/A **Cell Phone**: ___yes ___no ___N/A

2. **May we leave a message regarding your medical information on an answering machine or voice mail:**

   Home: ___yes ___no ___N/A **Work**: ___ yes ___no ___N/A **Cell Phone**: ___yes ___no ___N/A

3. **May we leave a phone message regarding your medical information with any of the persons listed below:**

   Home: ___yes ___no ___N/A **Work**: ___ yes ___no ___N/A **Cell Phone**: ___yes ___no ___N/A

List those persons to whom you permit Urology Associates of Houston, P.A., to discuss or release your medical information and their contact information..

______________________________ ______________________________

______________________________ ______________________________

* *

<u>INFORMATION TO YOUR PHYSICIAN(S)</u>

Urology Associates of Houston, P.A. will correspond with your referring physician and / or your primary care physician (PCP) regarding your diagnosis and treatment to coordinate your healthcare. Please list the name of your referring physician and / or primary care physician or write N/A: *If you have an HMO, you must list your PCP on file with your insurance company.*

DOCTOR:____

* *

<u>AUTHORIZATION FOR THE TRANSMISSION OF MEDICAL RECORDS BY FAX OR ELECTRONIC SUBMISSION</u>

I understand that Urology Associates of Houston, P.A., will be transmitting my medical records by fax in accordance with federal and Texas law, and I authorize you to do so. I also understand that Urology Associates of Houston, P.A. will be transmitting my medical records electronically and I authorize such transmission if the disclosure is made to another covered entity, as that term is defined in Urology Associates of Houston, P.A.'s Notice of Privacy Practices, for purposes of treatment, payment or health care operations or as otherwise authorized or required by Texas or federal law. I further understand that Urology Associates of Houston, P.A., must obtain my authorization for each electronic disclosure of my medical information that it makes for any other purpose. If another party inadvertently receives my medical records, I release Urology Associates of Houston, P.A., of any and all liability relating to such inadvertent submission of my records.

______________________________ ______________________
SIGNATURE OF PATIENT / PARENT / GUARDIAN DATE

Revised 10/12 (lh)

UROLOGY ASSOCIATES OF HOUSTON, P.A.

POLICY FOR INSURANCE PARTICIPANTS

If we are filing your insurance through a contracted plan, it is **YOUR RESPONSIBILITY** to notify the receptionist that you are on a certain plan and give your insurance card and/or referral to the receptionist ***BEFORE SERVICES ARE RENDERED***. Should you **NOT** have your insurance card and/or referral with you at the time of service, you will be asked to reschedule your appointment for a time when you can bring the insurance card and/or referral. **YOU MUST PRESENT A GOVERNMENT ID WITH YOUR PICTURE FOR US TO FILE YOUR INSURANCE.**

DEDUCTABLES AND CO-PAYMENTS WILL BE COLLECTED AT THE TIME OF THE VISIT, AND WE WILL BILL YOUR INSURANCE FOR THE BALANCE UNDER THESE PLAN PROVISIONS. WE HONOR ALL OUR INSURANCE CONTRACTS AND TAKE ADJUSTMENTS AS WE ARE INSTRUCTED BY OUR PAYORS. AFTER YOUR INSURANCE PAYS AND THE INSURANCE COMPANY SAYS THAT YOU STILL HAVE A BALANCE, YOU WILL BE RESPONSIBLE FOR THE BALANCE.

Some of the services rendered in this office are considered office surgery by your insurance company. This may result in a higher co-payment or charges may be subject to a surgical deductible and/or full payment of services rendered at the time of your visit.

If you understand and agree with this policy please sign below.

Thank You,

Dr.'s Barnes, Nguyen, Dow, Hoggatt and Vemana

________________________ Patient Signature

________________________ Patient Printed Name

Account # ____________

Date: ____________

NAME: ______________________ ACCOUNT # ____________

ADDRESS: ____
CITY STATE ZIP CODE

RACE: ***(Circle one)*** African-American, Asian, Caucasian -White, Hispanic, American Indian, Native Hawaiian, Pacific Islander, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Guamanian or Chamorro, Samoan, or OTHER.

PREFERRED LANGUAGE: ______________

Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) If YES, Which?______________

TELEPHONE NUMBERS

HOME ☎ ____________ WORK ☎ ____________ CELL ☎ ____________

APPPOINTMENT REMINDER CALLS ARE AUTOMATED. OUR COMPUTER IS PROGRAMED TO CALL YOUR <u>HOME PHONE AFTER 5:00 PM</u> THE NIGHT BEFORE YOUR APPOINTMENT.

CHECK THE PRIMARY PHONE NUMBER TO BE CALLED AFTER 5 PM: HOME ☐ WORK ☐ CELL ☐

◆ SOCIAL SECURITY # ______________ ◆ TEXAS DRIVERS LICENSE #____________

◆ DATE OF BIRTH: __________ ◆ __________ ◆ SEX (CIRCLE): MALE FEMALE

◆ PLEASE CHECK: MARRIED ☐ SINGLE ☐ WIDOW ☐ DIVORCED ☐ SEPARATED ☐

◆ SPOUSE NAME / GUARDIAN ______________

SPOUSE / GUARDIAN PHONE ☎ ______________

◆ PATIENT'S EMPLOYER ______________________________

ADDRESS____
CITY STATE ZIP

◆ NAME OF NEAREST FRIEND / RELATIVE ***NOT LIVING*** WITH YOU: NAME ______________

PHONE ______________

PRIMARY CARE PHYSICIAN OR
REFERRED BY DR. ______________________________

◈ INSURANCE CO. NAME (PRIMARY) ______________________________

CLAIMS ADDRESS ______________________________

POLICY
HOLDER NAME ______________ DATE OF BIRTH __________ SOCIAL SECURITY # __________

PATIENT RELATIONSHIP TO THE POLICY HOLDER (*PLEASE CHECK*): SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

MEMBER ID # ______________ GROUP # __________ EMPLOYER ______________

◈ INSURANCE CO. NAME (SECONDARY) ______________________________

CLAIMS ADDRESS ______________________________

POLICY
HOLDER NAME ______________ DATE OF BIRTH __________ SOCIAL SECURITY #__________

PATIENT RELATIONSHIP TO THE POLICY HOLDER (*PLEASE CHECK*): SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

MEMBER ID # ______________ GROUP # __________ EMPLOYER______________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR FOR THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. I AUTHORIZE PAYMENT OF MEDICAL TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES.

PATIENT OR GUARDIAN SIGNATURE______________________________ DATE__________

Name: ______________________ **DOB:** ____________ **ACCT.** ____________ **Date:** ________

REFERRING DOCTOR: ________________ FAMILY DOCTOR: ____________________

PHARMACY: ________________ ADDRESS ____________________ CITY ____________ TELEPHONE ____________

WHY ARE YOU SEEING THE DOCTOR TODAY? ______________________________

HOW LONG HAVE YOU HAD THIS PROBLEM? ______________________________

PAST MEDICAL HISTORY PLEASE *CIRCLE* if you *have* or *have had* any of the following diseases or conditions *or* mark none of the above:

CARDIOVASCULAR
Anemia
Angina (Chest Pain)
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhythmia (Irregular Heartbeat)
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication (Pain in legs w/exercise)
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis (Blood clots)
Endocarditis (Heart Infection)
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia
☐ **NONE OF THE ABOVE**

ENDOCRINE/METABOLIC
Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyroidism (High)
Hypothyroidism (Low)
Impaired Glucose Tolerance (Borderline Diabetes)
☐ **NONE OF THE ABOVE**

GENERAL
ALLERGIES
ELECTRICAL Injury
Exposure to Chemicals
Hepatitis A
Hepatitis B

GENERAL (continued)
Hepatitis C
Hypercholesterolemia (High Cholesterol)
Hyperlipidemia
Infectious Disease
Lipid Disorder
Malaise (Weak/Tired)
Obesity
Paget's Disease
Polycystic Ovaries
Raynaud's Syndrome
Sleep Apnea
Hernia Location: ____________
☐ **NONE OF THE ABOVE**

GI
Cholecystits (Gall Bladder Disease)
Cholelithiasis (Gallstones)
Chronic Liver Disease
Colitis
Constipation
Colon Condition (explain:
Crohn's Disease
Diarrhea
Diverticulitis
GERD (Acid Reflux, Indigestion)
Hemorrhoids
Hepatic Failure (Liver Failure)
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis
☐ **NONE OF THE ABOVE**

GU
Aids
Bladder Cancer
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency
Chronic Renal Failure
Crossed Fused Ectopia
Erectile Dysfunction
Hematuria
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones

GU (continued)
Libido Decreased (low sex drive)
Neurogenic Bladder
Orchitis (Testicular Infection)
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure
Recurrent UTI
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Ureteral Cancer
Undescended Testicle
Urinary Tract Infection
Venereal Disease (STD)
☐ **NONE OF THE ABOVE**

GYN/OB
Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids
☐ **NONE OF THE ABOVE**

HEENT
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Meniere's
Mumps
Sinusitis
Tinnitus (Ringing in ears)
Vertigo (Dizziness)
☐ **NONE OF THE ABOVE**

MUSCULOSKELETAL
Arthritis
Back Pain
Carpal Tunnel Syndrome
Claudication (Pain in legs with exercise)
Fibromyalgia
Morton's Neuroma
☐ **NONE OF THE ABOVE**

NEURO/PSYCH
ADHD

Name: ______________________ **DOB:** ____________ **ACCT.** ____________ **Date:** ________

NEURO/PSYCH (Continued)
Alcoholism
Alzheimer's Disease
Anxiety
Bi-Polar Disorder
Chronic Fatigue Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt
☐ NONE OF THE ABOVE

RESPIRATORY
Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis (TB)
☐ NONE OF THE ABOVE

TUMORS
Brain Cancer
Brain Tumor
Breast Cancer
Cervical Cancer

TUMORS (Continued)
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer (Stomach)
Laryngeal (Throat) Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Renal Cell Cancer (kidney)
Sarcoidosis
Testicular Cancer
Bladder Cancer
Ureter Cancer
Uterine Cancer
☐ NONE OF THE ABOVE

PLEASE LIST ANY OTHER DISEASES OR CONDITIONS: ____

____

____

SURGICAL HISTORY PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING SURGERIES AND INDICATE THE YEAR OF SURGERY:

CARDIOVASCULAR	YEAR
Angioplasty	______
Aortic Aneurysm Repair	______
CABG	______
Carotid Artery Surgery	______
Defibrillation	______
Heart Surgery (Stents)	______
Heart Transplant	______
Pacemaker Insertion	______
Vein Stripping	______

GENERAL	YEAR
Brain Surgery	______
Disc Surgery	______
Lymphatic Node Dissection	______
Parathyroidectomy	______
Pilonidal Cyst Incision	______
Skin Grafting	______

GI	YEAR
Appendectomy	______
Bariatric Surgery	______
Bowel Resection	______
Cholecystectomy	______
Colon Resection	______
Colonoscopy	______
EGD	______
EGD/Dilation Esophagus	______
Fissurectomy	______
Gall Bladder Surgery	______
Hemorrhoidectomy	______
Ileostomy	______
Laparascopy	______
Liver Surgery	______
Liver Transplant	______
Lumpectomy of Breast	______

GI (Continued)	YEAR
Lysis Adhesions	______
Nissen Fundoplication	______
Splenectomy	______
Stomach Surgery	______
Umbilical Hernia	______
Ventral Hernia Repair	______

GU	YEAR
Bladder Surgery	______
Biopsy Prostate	______
Brachytherapy	______
Circumcision	______
Contigen	______
Cystoscopy	______
Cystoscopy – Dilation	______
Cystoscopy – Retrograde	______
Cystoscopy – Stent	______
Cystoscopy – TUR Fulg	______
Durashpere	______
Epididymectomy	______
ESWL (Shockwave Stones)	______
Hernia Repair	______
Hydrocelectomy	______
Ileal Conduit	______
Indigo Laser Surgery	______
Inguinal (Groin) Hernia	______
Interstim	______
Kidney Stone	______
Laser Treatment of Stone	______
Meatotomy	______
Needle Biopsy Prostate	______
Nephrectomy (Removal of Kidney)	______
Nephrolithotomy (Removal of stones)	______
Orchiectomy	______
Orchiopexy	______

GU (Continued)	YEAR
Penile Implant/Prosthesis	______
Penectomy	______
Penile Surgery	______
Pyeloplasty	______
Radical Prostatectomy	______
Renal Transplant	______
Spermatocelectomy	______
TUMT Prostate (Microwave)	______
TUNA Prostate	______
TURBT (Bladder Tumor)	______
TUR Prostate	______
Ureteroscopy	______
Varicelectomy	______
Vasectomy	______
VLAP (Laser Ablation of Prostate)	______

GYN	YEAR
Colposcopy	______
Culdocentesis	______
Hysterectomy	______
Oopherectomy (Ovaries)	______
Salpingectomy (Tubes)	______
Tubal Litgation	______
Vaginectomy	______
Vulvectomy	______

HEENT	YEAR
Cataract Surgery	______
Corneal Surgery	______
Ear Surgery	______
Eye Surgery	______
Facial Surgery	______
Mastoid Surgery	______
Nasal Surgery	______

Name: ______________________ **DOB:** ______________ **ACCT.** ____________ **Date:** __________

HEENT (Continued) — YEAR
- PEG (feeding tube) ______
- Septoplasty ______
- Sinus Surgery ______
- Tonsil Surgery ______
- Thyroid Surgery ______
- TMJ Surgery ______

MUSCULOSKETAL ______
- Amputation ______
- Arthroscopic Knee Surgery ______
- Back Surgery ______
- Carpal Tunnel Surgery ______

MUSCULOSKETAL (Continued) — YEAR
- Cervical Spine Surgery ______
- Disc Surgery ______
- Foot Surgery ______
- Hand Surgery ______
- Hip Surgery ______
- Knee Surgery ______
- Leg Surgery ______
- Rotator Cuff Surgery ______
- Shoulder Surgery ______

REPIRATORY — YEAR
- Lung Surgery ______

SKIN ______
- Basal Cell Carcinoma ______
- Melanoma ______
- Squamous Cell Carcinoma ______

☐ **NO PRIOR SURGICAL HISTORY**

PLEASE INDICATE THE DATE(S) OF ANY OTHER SURGERIES AND DESCRIBE:______________________________

____

____

FAMILY HISTORY

PLEASE INDICATE WHICH FAMILY MEMBER HAS/HAD ANY OF THE FOLLOWING: (MOTHER, FATHER, BROTHER/SISTER, GRANDMOTHER, GRANDFATHER, AUNT AND UNCLE).

Arthritis	______	Leukemia	______
Bedwetting	______	Liver Disease	______
Bladder Cancer	______	Malignant Melanoma	______
Cancer (site unknown)	______	Multiple Sclerosis	______
Crohn's Disease	______	Laryngeal (Throat) Cancer	______
Depression	______	Pancreatic Cancer	______
Diabetes	______	Prostate Cancer	______
Gout	______	Stroke	______
Heart Attack	______	Thyroid Disease	______
Hypertension	______	Tuberculosis	______
Kidney Cancer	______		
Kidney Disease		OTHER	______

☐ **UNREMARKABLE FAMILY HISTORY**

SOCIAL HISTORY
MARITAL STATUS:

______ Single ______Married ______Separated _____Divorced _____Widowed _____Life Partner ____Common Law Spouse

Occupation:______________________________ **Number of Dependents (children):**_________

Alcohol Consumption: _____None _____Yes ____Occasional/Social # of drinks per day _______

Tobacco per day: _____None ______Yes #______Packs/day ______Cigarettes/day _____Smokeless Tobacco

If you previously smoked, when did you quit? ________________________

Caffeinated beverages: None Low(1-2) Moderate (3-4) Excessive (5 or more)

Name: ______________________ DOB: ____________ ACCT. ____________ Date: ________

ALLERGIES - DO YOU HAVE ANY ALLERGIES: YES ☐ NO ☐ PLEASE LIST ALL TYPES (Drug, seasonal, pets, environmental foods):

____

____

____

CURRENT MEDICATIONS ☐ **NONE** ☐ **LIST PROVIDED**

Drug Name:	Dosage:	Directions/How you take it:

REVIEW OF SYSTEMS: Please circle if you have *recently* experienced any of the following *or* mark none of the above:

CONSTITUTIONAL
Fever
Fatigue
Generalized Weakness
Weight Gain
Weight Loss
☐ NONE OF THE ABOVE

EYES
Blurred Vision
Cataracts
Glasses
Glaucoma
Worsening Eyesight
☐ NONE OF THE ABOVE

ALLERGIC/IMMUNOLOGIC
Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies
☐ NONE OF THE ABOVE

NEUROLOGICAL
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors
☐ NONE OF THE ABOVE

ENDOCRINE
Diabetes
Excessive Thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold
☐ NONE OF THE ABOVE

GASTROINTESTINAL
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/Heartburn
Irregular Bowel Movements
Nausea/Vomiting
Rectal Bleeding
Tarry Stool
☐ NONE OF THE ABOVE

CARDIOVASCULAR
Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse

CARDOVASCULAR (Continued)
Orthopnea
Pain/Cramps Hips/Legs with exercise
Palpitation
Skipped Heart Beats
Swelling
☐ NONE OF THE ABOVE

SKIN
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin Rash
☐ NONE OF THE ABOVE

MUSCULOSKELETAL
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness
☐ NONE OF THE ABOVE

EAR / NOSE / THROAT
Ear Infection
Sinus Problem
Sore Throat
☐ NONE OF THE ABOVE

GENITOURINARY
Back Pain
Bedwetting
Blood in Urine

Name: ______________________ DOB: ______________ ACCT. ____________ Date: ________

REVIEW OF SYSTEMS: **Please circle if you have *recently* experienced any of the following *or* mark none of the above:**

GENITOURINARY (Continued)
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Stranguria
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy

GENITOURINARY (Continued)
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream
☐ NONE OF THE ABOVE

RESPIRATORY
Asthma
Emphysema-Bronchitis
Environmental Allergies
Pneumonia
Frequent Cough
Shortness of breath
Tuberculosis
Wheezing
☐ NONE OF THE ABOVE

HEMATOLOGICAL / LYMPHATIC
Swollen Glands
Blood Clotting Problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell
☐ NONE OF THE ABOVE

PSYCHOLOGIC
Anxiety
Depressed
Generally Satisfied with Life
☐ NONE OF THE ABOVE

UROLOGY ASSOCIATES OF HOUSTON, P.A.

Nathaniel L Barnes MD, F.A.C.S.
Diplomat American Board of Urology

Thanh A. Nguyen MD, F.A.C.S.
Diplomat American Board of Urology

Douglas S Dow MD, F.A.C.S.
Diplomat American Board of Urology

Matthew D. Hoggatt M.D.
Diplomat American Board of Urology

Goutham Vemana M.D.

BLADDER QUESTIONAIRE

		YES	NO
1.	Do you leak urine when you cough, sneeze, laugh or exercise?	____	____
2.	If your answer to #1 was "yes", on average how much do you leak: ______"Drops" ______ "Tablespoons" _______"Flood"	____	____
3.	If applicable has your leakage worsened over the last year?	____	____
4.	Do you ever leak urine without awareness that you are leaking?	____	____
5.	Are you wet upon awakening in the morning?	____	____
6.	Do you ever leak urine during sexual intercourse?	____	____
7.	When you have the "urge" to urinate, must you stop and go to the bathroom because it is such a strong urge?	____	____
8.	Do you ever leak urine when you have a strong urge to urinate? (for example: you leak before you can get your underwear off)	____	____
9.	If your answer to #8 was "Yes", on average how much do you leak: ______"Drops" ______ "Tablespoons" _______"Flood"	____	____
10.	On average, how many times during the day do you urinate?	____	____
11.	On average, how many times do you urinate after going to sleep?	____	____
12.	Do you have a problem with vaginal dryness?	____	____
13.	If you have gone through menopause, do you take hormone replacement medication?	____	____
14.	Do you feel that your urinary stream is restricted or slow?	____	____
15.	Do you have the sensation that after urinating you have fully emptied?	____	____
16.	Do you have to wear a pad or protective undergarment for leaking?	____	____
17.	If the answer to #16 was "Yes", how many times do you change daily?	____	____

ACCOUNT # ____________________

NAME: ____ AGE:______ **DATE:**______________

NAME: ______________________ ACCOUNT: ______________

DATE OF BIRTH: ____________ AGE: _______ DATE: ______________

Referring Physician: ______________________ Primary Care Physician: ______________________

REVIEW OF SYSTEMS: **Please circle if you have *recently* experienced any of the following:**

CONSTITUTIONAL
Fever

EYES
Blurred Vision

ALLERGIC / IMMUNOLOGIC
Drug Allergies
Environmental Allergies

NEUROLOGICAL
Dizzy Spells
Headache
Numbness / Tingling
Tremors

GASTROINTESTINAL
Nausea / Vomiting

CARDIOVASCULAR
Chest Pain / Angina
High Blood Pressure

GENITOURINARY
Back Pain
Bedwetting
Blood in urine
Flank Pain

GENITOURINARY (continued)
Kidney Failure
Kidney Infections
Kidney Stones
Leak after Voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Painful Ejaculation
Scrotal Pain
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge / Problems
Weak Stream

RESPIRATORY
Shortness of Breath
Wheezing

Other symptoms not listed:

____
____
____

List any new diagnosis since your last visit.
IF NONE CHECK THIS BOX ☐

____
____
____

If you have had any surgery since your last visit, list the surgery and the date below.
IF NONE CHECK THIS BOX ☐

____
____
____

IF YOU HAVE NOT EXPERIENCED <u>ANY</u> OF THE ABOVE SYMPTOMS CHECK THIS BOX ☐

****

Do you currently use tobacco? Yes or No

How many packs per day do you smoke? ______ Do you use smokeless tobacco? Yes or No

Have you previously used tobacco? Yes or No If yes, when did you quit? __________

How may packs per day did you smoke? ________

CURRENT MEDICATIONS: ☐ NONE ☐ LIST PROVIDED

DRUG NAME	*DOSAGE*	*DIRECTIONS/HOW YOU TAKE IT*

USING A NEW PHARMACY? IF SO, GIVE US YOUR NEW PHARMACY INFORMATION BELOW:

NEW PHARMACY NAME ______________ ADDRESS ______________ PHONE# ______________

PATIENT SIGNATURE: ______________________ DATE: ____________