

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.

250 BLOSSOM STE 220
WEBSTER TX 77598
281-332-0202

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

3315 BURKE RD STE 201
PASADENA TX 77504
713-910-9428

8615 W BROADWAY STE 101
PEARLAND TX 77584

******Please arrive 30 minutes prior to your appointment***
With your completed paperwork***

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, _____ Account # _____ have received a copy of Urology Associates of Houston, P.A.'s
Notice of Privacy Practices.

SIGNATURE OF PATIENT / PARENT / GUARDIAN

DATE

You may notify us now your request for confidential communication & restrictions.

Please indicate where we may contact you: (Please mark YES, NO, OR N/A)

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

May we leave a message regarding your IIHI on answering machine/voice mail/ person at:

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

You may list other person(s) who may receive your medical information. All information shall be held in
confidence and shall not be disclosed to any person, EXCEPT upon the expressed consent of the patient or by the guidelines
of his/her medical insurance.

INFORMATION TO YOUR PHYSICIAN(S)

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: _____

MEDICAL RECORDS FAX TRANSMISSION AUTHORIZATION

I understand that Urology Associates of Houston, P.A., will be transmitting my medical records electronically and authorize
you to do so. If another party receives them, I absolve Urology Associates of Houston, P.A. of any and all liability relating to
such submission of said records.

SIGNATURE OF PATIENT / PARENT / GUARDIAN

DATE

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.

DEDUCTIBLES 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 Hurwitz, Barnes, Nguyen, Dow and Hoggatt

Patient Signature

Patient Printed Name

Account # _____

Date: _____

NAME: _____

ACCOUNT # _____

ADDRESS: _____

CITY STATE ZIP CODE

RACE: *(Circle one)* African-American, Asian, Caucasian, Hispanic, Native American, 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 ☎ _____

APPOINTMENT REMINDER CALLS ARE AUTOMATED. OUR COMPUTER IS PROGRAMED TO CALL YOUR HOME PHONE AFTER 5:00 PM 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: _____ ◆ AGE: _____ ◆ SEX: _____

◆ PLEASE CHECK: MARRIED SINGLE ◆ SPOUSE NAME / GUARDIAN _____

WIDOW DIVORCED SEPARATED 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 _____

Gary S Hurwitz MD, F.A.C.S.
Diplomat American Board of Urology

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

AUA SYMPTOM INDEX FOR BPH

COULD YOUR MALE URINARY SYMPTOMS BE CAUSED BY BPH?

Answer these simple questions and share them with your doctor.

- | | | Not
at all
0 | Less than
1 time in 5
1 | Less than
Half the time
2 | About half
the time
3 | More than
Half the time
4 | Almost
always
5 |
|---|--|--------------------|-------------------------------|---------------------------------|-----------------------------|---------------------------------|-----------------------|
| 1 | INCOMPLETE EMPTYING
Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating? | | | | | | |
| 2 | FREQUENCY
During the last month, how often have you had to urinate again less than 2 hours after you finished urinating? | | | | | | |
| 3 | INTERMITTENCY
During the last month, how often have you stopped and started again several times when you urinated? | | | | | | |
| 4 | URGENCY
During the last month, how often have you found it difficult to postpone urination? | | | | | | |
| 5 | WEAK STREAM
During the last month, how often have you had a weak urinary stream? | | | | | | |
| 6 | STRAINING
During the last month, how often have you had to push or strain to begin urination? | | | | | | |
| 7 | NOCTURIA
During the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? | | | | | | |

Now add up your symptom Score (1-7 Mild, 8-19 Moderate, 20-35 Severe): _____

The Disease Specific Quality of Life Question

The International Prostate Symptom Score uses the same 7 questions as the AUA Symptom Index (presented above) with the addition of the following Disease Specific Quality of Life Question (bother score) scored on a scale from 0 to 6 points (delighted to terrible).

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? _____

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Disappointed	Unhappy	Terrible
0	1	2	3	4	5	6

Adapted from American Urological Association. *Guideline on the Management of Benign Prostatic Hyperplasia (BPH)*. Linthicum, MD: American Urological Association Education and Research, Inc.: 2003: 1-22, 1-23, 3-51.

NAME _____ ACCOUNT# _____ AGE: _____ 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
Goit
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

Cholecystitis (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
Uncircumcised 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
Meningitis
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

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

YEAR

GI (Continued)

Lysis Adhesions
 Nissen Fundoplication
 Splenectomy
 Stomach Surgery
 Umbilical Hernia
 Ventral Hernia Repair

YEAR

GU (Continued)

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

YEAR

GENERAL

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

GU

Bladder Surgery
 Biopsy Prostate
 Brachytherapy
 Circumcision
 Contigen
 Cystoscopy
 Cystoscopy – Dilation
 Cystoscopy – Retrograde
 Cystoscopy – Stent
 Cystoscopy – TUR Fulg

GYN

Colposcopy
 Culdcentesis
 Hysterectomy
 Oophorectomy (Ovaries)
 Salpingectomy (Tubes)
 Tubal Litigation
 Vaginectomy
 Vulvectomy

GI

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

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

HEENT

Cataract Surgery
 Corneal Surgery
 Ear Surgery
 Eye Surgery
 Facial Surgery
 Mastoid Surgery
 Nasal Surgery

Name: _____ DOB: _____ ACCT. _____ Date: _____

<u>HEENT (Continued)</u>	YEAR	<u>MUSCULOSKETAL (Continued)</u>	YEAR	<u>REPIRATORY</u>	YEAR
PEG (feeding tube)	_____	Cervical Spine Surgery	_____	Lung Surgery	_____
Septoplasty	_____	Disc Surgery	_____		_____
Sinus Surgery	_____	Foot Surgery	_____	<u>SKIN</u>	_____
Tonsil Surgery	_____	Hand Surgery	_____	Basal Cell Carcinoma	_____
Thyroid Surgery	_____	Hip Surgery	_____	Melanoma	_____
TMJ Surgery	_____	Knee Surgery	_____	Squamous Cell Carcinoma	_____
		Leg Surgery	_____		
<u>MUSCULOSKETAL</u>		Rotator Cuff Surgery	_____		
Amputation	_____	Shoulder Surgery	_____		
Arthroscopic Knee Surgery	_____				
Back Surgery	_____				
Carpal Tunnel Surgery	_____				

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, SIBLINGS, 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		OTHER	
Kidney Disease			

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

ENDOCRINE

- Diabetes
- Excessive Thirst
- Thyroid Disease
- Tired/Sluggish
- Too Hot/Cold
- NONE OF THE ABOVE

CARDIOVASCULAR (Continued)

- Pain/Cramps Hips/Legs with exercise
- Palpitation
- Skipped Heart Beats
- Swelling
- NONE OF THE ABOVE

EYES

- Blurred Vision
- Cataracts
- Glasses
- Glaucoma
- Worsening Eyesight
- 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

SKIN

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

ALLERGIC/IMMUNOLOGIC

- Animal Allergies
- Drug Allergies
- Environmental Allergies
- Food Allergies
- Seasonal Allergies
- NONE OF THE ABOVE

MUSCULOSKELETAL

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

NEUROLOGICAL

- Balance Problems
- Disoriented
- Dizzy Spells
- Headache
- Lack of Alertness
- Leg and Arm Weakness
- Memory Loss
- Numbness/Tingling
- Stroke
- Seech Problems
- Tremors
- 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
- Orthopnea

EAR/NOSE/THROAT

- Ear Infection
- Sinus Problem
- Sore Throat
- NONE OF THE ABOVE

GENITOURINARY

- Back Pain
- Bedwetting
- Blood in Urine
- Dribbling

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

- 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