

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

BLADDER QUESTIONNAIRE

- | | 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? | _____ | _____ |

PATIENT NAME _____ AGE _____

ACCT.# _____

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
Arythmia (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
Unscended 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

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

GENERAL

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

GI

- Appendectomy _____
- Bariatric Surgery _____
- Bowel Resection _____
- Cholecystectomy _____
- Colon Resection _____
- Colonoscopy _____
- EGD _____
- EGD/Dilation Esophagus _____
- Fissurectomy _____
- Gall Bladder Surgery _____
- Hemorrhoidectomy _____
- Ileostomy _____
- Laparoscopy _____
- Liver Surgery _____
- Liver Transplant _____
- Lumpectomy of Breast _____

YEAR

GI (Continued)

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

GU

- 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 _____

YEAR

GU (Continued)

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

YEAR

GYN

- Colposcopy _____
- Culdocentesis _____
- Hysterectomy _____
- Oophorectomy (Ovaries) _____
- Salpingectomy (Tubes) _____
- Tubal Litgation _____
- Vaginectomy _____
- Vulvectomy _____

HEENT

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

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

<u>HEENT</u> (Continued)	YEAR	<u>MUSCULOSKETAL</u> (Continued)	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