UROLOGY CLINICS OF NORTH TEXAS

ADULT HEALTH HISTORY FORM

PATIENT NAME:_____ **DATE:**____/__/____ **MED REC #:**_____

DATE OF BIRTH:____/___/____ **AGE:**____ **HEIGHT:**____FT____IN **WEIGHT:**____LBS

Social Security #____/____/____ **Email Address:**_____

Reason for your visit today: _____

Name of Referring Physician:_____ **Referring Physician's Phone #:**_____

Referring Physician's Address:_____

Primary Care Physician (if Different)_____ **Phone #:**_____

Race: ❒White ❒Black ❒Hispanic/Latino ❒Asian ❒Other: _____ Sex: ❒Female ❒Male

Ethnicity: ❒ **Hispanic/Latino** ❒ **Non Hispanic/Latino**

Pharmacy Name:_____ **Address:**_____ **Phone:**_____

Pharmacy Name:_____ **Address:**_____ **Phone:** _____

Drug Allergies: _____

Other Allergies:_____

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely:

Name of Drug or Supplement:	Strength (mg):	How often (# of times per day)

REVIEW OF SYSTEMS: Please mark all yes or no **All Negative**

Constitutional--❒Neg

No Yes

❍ ❍ chills

❍ ❍ fever

Respiratory--❒Neg

No Yes

❍ dyspnea (shortness of breath)

Gastrointestinal-❒Neg

No Yes

❍ ❍ diarrhea

Metabolic/Endocrine--- ❒Neg

No Yes

❍ ❍ Excessive Thirst

Musculoskeletal-❒Neg

No Yes

❍ ❍ back pain

Heent---❒Neg

No Yes

❍ ❍ double vision

Cardiovascular--❒Neg

No Yes

❍ ❍ chest pain

Integumentary--❒Neg

No Yes

❍ ❍ rash

Psychiatric--❒Neg

No Yes

❍ ❍ anxiety

Neurological--❒Neg

No Yes

❍ ❍ seizures

Hema/Lymphatic-❒Neg

No Yes

❍ ❍ easy bleeding

❍ ❍ petechiae/easy bruising

MEDICAL HISTORY: Please check or list any conditions which YOU have had or presently have:

❒Allergies
❒Anemia
❒Arthritis
❒Asthma
❒Bleeding disorder
❒BPH
❒Cancer _____
❒Chest pain
❒Congestive Heart Failure
❒COPD
❒Coronary Artery Disease
❒Depression
❒Diabetes
❒Diverticular disease
❒GERD
❒Gout
❒Heart Attack
❒Hepatitis C
❒Hyperlipidemia
❒High Blood Pressure
❒Inflammatory bowel
❒Kidney Stones
❒Migraine headaches
❒Osteoporosis
❒Parkinson's Disease
❒Peptic Ulcer disease
❒Peripheral vascular disease
❒Renal/Kidney disease
❒Seizure disorder
❒Stroke
❒Thyroid disease
❒Urinary tract infection
❒Valvular heart disease

FEMALES ONLY ♀
Last Period _____
Last PAP _____
#Pregnancies_____
Deliveries_____

LIST OTHER CONDITIONS

Patient Name:_____ **Med Rec-#:**

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure

GENERAL	Year		Year		Year		Year		Year
❒ Angioplasty		❒ Dialysis		❒ Pacemaker, Cardiac		❒ Ureteral Stent		❒ Orchiectomy (Male)	
❒ Appendectomy		❒ Gastric Bypass		❒ Radiation treatment		❒ Ureteroscopy		❒ Penile Prosthesis (Male)	
❒ Back Surgery		❒ Heart Valve surgery		**Urology**		❒ Hysterectomy (Female)		❒ Prostate Biopsy (Male)	
❒ Blood Transfusion		❒ Hemorrhoidectomy		❒ TURBT		❒ Bilateral Oophorectomy (Female)		❒ Prostatectomy for cancer (Male)	
❒ CABG		❒ Herniorrhaphy		❒ Cystoscopy		❒ Tubal Ligation (Female)		❒ TURP (Male)	
❒ Cataract surgery		❒ Hip replacement		❒ Nephrectomy		❒ Urethral Sling (Female)		❒ Varicocele Ligation (Male)	
❒ Cholecystectomy		❒ Knee replacement		❒ Lithotripsy		❒ Hydrocelectomy		❒ Vasectomy	
❒ Colectomy		❒ Laparoscopy		❒ Percutaneous		❒ Laser of Prostate			

LIST ANY OTHER SURGERIY/YEAR HERE

_____ _____

_____ _____

FAMILY HISTORY: Please check any of the following conditions that apply to your family members and list their relation to you:

Diagnosis:	Yes	No	Relationship:		Diagnosis:	Yes	No	Relationship
Cancer					High Cholesterol			
Type:					High Blood Pressure			
Cardiovascular disease					Inflammatory bowel disease			
CVA / Stroke					Kidney stones			
Diabetes					Renal failure			
Genetic Disease					Seizure disorder			
Gout					Thyroid disorder			

Alive & Well: ❒Father ❒Mother ❒Brother ❒Sister

*****TOBACCO:**

Uses tobacco? ❒Current ❒Former ❒Never ❒Unknown

Tobacco type:_____ Packs per day:_____ Years used:_____ Pack Years: _____

Year quit:_____ Longest tobacco free:_____ Relapse reason:_____

◯ Current every day smoker ◯ Smoker, current status unknown ◯ Former smoker

◯ Current some day smoker ◯ Never smoker ◯ Unknown if ever smoked

*****ALCOHOL:** ❒Yes ❒No ❒formerly Year quit: _____

Type:_____ Frequency:_____ Amount:_____

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____ times

CAFFEINE: ❒Yes ❒No

Type:_____ Type:_____

Amount daily: _____ Amount daily: _____

Marital/Family Status:

Current Status: ❒Single ❒Married ❒Divorced ❒Widowed Previously widowed? ❒Yes ❒No Previous divorce?❒Yes ❒No

Do you have children? ❒Yes ❒No If so, number: _____

LIFESTYLE:

Occupation:_____

Exercise? ❒Yes ❒No If yes, Type:_____ Frequency:_____ per_____ Hours per week: _____

4. PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand UROLOGY CLINICS OF NORTH TEXAS is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize UROLOGY CLINICS OF NORTH TEXAS or UROLOGY CLINICS OF NORTH TEXAS designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

1. Description of the information to be used or disclosed (check as appropriate):

☐ **a. My entire record:**

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply)**:

- ☐ Alcohol and Drug Abuse Treatment*
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment
- ☐ Genetic Information (including, but not limited to, Genetic Test Results).

(NOTE: If you checked "my entire record," please skip to number 2. Otherwise, please continue with b. and c. below.)

☐ **b. My demographic information (check "All" or those that apply):**

☐ All ☐ Age ☐ Gender ☐ Race ☐ Other_____
☐ Name ☐ Address ☐ State/Zip Code Only ☐ Telephone

☐ **c. Medical Data/Information as related to (check all that apply):**

- ☐ Specific condition(s):_____
- ☐ Specific professional service(s):_____
- ☐ Specific medication(s):_____
- ☐ Alcohol and Drug Abuse Treatment:*
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment:_____
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS):_____
- ☐ Genetic Information including, but not limited to, Genetic Test Results:
- ☐ Other: _____

2. Please disclose the above information to:

Name:_____ Relation: _____

Name:_____ Relation: _____

Name:_____ Relation: _____

3. I ☐ do ☐ do not authorize this information to be disclosed electronically.

4. Purpose(s) for disclosure of the information:

_____

_____

(NOTE: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure.")

5. **Right to revocation**. I have a right to revoke this authorization in writing (or orally in the case of Part 2 alcohol and drug abuse services), except to the extent that action has been taken in reliance on this authorization. UROLOGY CLINICS OF NORTH TEXAS must receive the revocation in writing (except for Part 2 alcohol and drug abuse services) and the written revocation must include:

a. My name and address,
b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
c. My desire to revoke this authorization, and
d. The date of the revocation, and my signature.

UROLOGY CLINICS OF NORTH TEXAS will accept written revocations of this authorization via:

☐ Certified U.S. mail
☒ Facsimile at this number: **214-889-9625**

ALL written revocations must be sent to Cassandra Rodriguez, and are not effective until received by her.

6. **This authorization shall expire upon patient revocation or revision.** After this date/event, UROLOGY CLINICS OF NORTH TEXAS can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

7. I fully understand and accept the terms of this authorization.

_____	_____
Signature of Patient or Patient's Representative	**Date**
_____	
Name of Patient	
_____	_____
Name of Representative (if applicable)	**Description of Representative's authority to act for patient**

***CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ **I give Urology Clinics of North Texas permission to send appointment reminders via text messaging. Please send messages to the following number: _____**

☐ **At this time, I do not want Urology Clinics of North Texas to send appointment reminders via text messaging**

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by Urology Clinics of North Texas, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

I also acknowledge that I have been afforded the opportunity to read the *Notice of Privacy Practices* and ask questions.

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

☐ **I give Urology Clinics of North Texas permission to send appointment reminders via text messaging. Please send message to the following number: (_____) _____ - _____**

☐ **At this time, I do not want Urology Clinics of North Texas to send appointment reminders via text messaging**

Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:
Month:_____ Day:_____ Year:_____.

SIGNATURES:

Patient/Legal Representative:_____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) :_____ Date:_____

International Prostate Symptoms Score (I-PSS)

Patient Name:_____Date of Birth:_____Date Completed:_____

In the Past Month	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PPS Score							

Score: 1-7: Mild 8-19: Moderate 20-35: Severe

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	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?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

SEXUAL HEALTH INVENTORY FOR MEN

Select the number that best describes your situation. Enter that number in the blank to the left of the question.
Please be sure that you select only one response to each question.

Over the past 6 months:

___A) How do you rate your confidence that you could get and keep an erection?
1) Very low 2) Low 3) Moderate 4) High 5) Very high

___B) When you had erections with sexual stimulation, how often were erections hard enough for penetration (entering your partner)?
0) No sexual activity 1) Almost never or never 2) A few times-less than 1/2
3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always

___C) During sexual intercourse, howoften were you able to maintain your erection after you had penetrated (entered your partner)?
0) Did not attempt intercourse 1) Almost never or never 2) A few times-less than 1/2
3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always

___D) During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
0) Did not attempt intercourse 1) Extremely difficult 2) Very difficult
3) Difficult 4) Slightly difficult 5) Not difficult

___E) When you attempted sexual intercourse, how often was it satisfactory for you?
0) Did not attempt intercourse 1) Almost never or never 2) A few times-less than 1/2
3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always

Patient Name:_____ MR #:_____

Financial Policy

All copayments, coinsurance and applicable deductible amounts are due at the time of service. Please be advised that the eligibility and benefit information supplied by your insurance company is only an estimate and not a guarantee of payment. Actual benefits are subject to all plan terms, definitions, limitations, and exclusions in effect on the date of service. In-office procedures and diagnostic testing are typically applied by your insurance company towards your deductible, co-insurance or other out-of-pocket expenses and are due at the time of service.

It is the patient's responsibility to obtain all referral certifications from the primary care or referring physician when required by your insurance plan. If you do not have a current referral on file, you will be asked to reschedule your appointment.

Urology Clinics of North Texas will submit your bill to your insurance for services performed by our physicians; however it is ultimately the patient's responsibility to pay for any and all services provided.

If you (1) do not have insurance coverage, (2) choose not to use your insurance coverage, or (3) are seeking treatment/services that are not covered by your insurance plan, you are a "self-pay" patient. Upon your arrival, a $250 deposit is required. As you leave, you must pay for any remaining balance for the services provided.

Financial Disclosure

Please be advised the physicians at Urology Clinics of North Texas, PLLC may be a limited partner in the following entities: North Texas Lithotripsy, Texas Institute for Surgery at Texas Health Presbyterian, Texas Health Center for Diagnostics and Surgery Plano, Texas Health Surgery Center Craig Ranch, Texas Health Presbyterian Flower Mound, Nextmed LP, North Central Surgery Center, Methodist Southlake Center, Baylor Surgicare, Prostate Seed Institute LP, Ethicus, USPI, Texas Health Resources Addison, P4 Diagnostix, and UCNT Ancillary Departments including UroPharmacy, Imaging and Radiation Centers in Trophy Club and Dallas Texas. Your physician's ownership interest in the above entities means that your physician may benefit from choosing to provide services to you at this facility. If your physician recommends you obtain services at one of these applicable facilities, you should know that the choice of facilities and/or medical provider is up to you and you only and if you would like information about other providers and/or facilities who are available to provide these services, we will be glad to provide you with this information. Acceptance of the herby advises you that you have the right to choose to be treated at an alternative facility. Acceptance of the recommended referral to the above entities is not required to continue to receive ongoing care from your physician.

I have read and understand the above statement.

_____ _____

Patient Signature Date

_____ _____

Patient Name Printed Medical Record Number