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:** _____ **City:**_____ **Zip:**_____

Pharmacy Phone #:_____ **Pharmacy Fax #:** _____

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

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

Neurological--❒Neg

No Yes
❍ ❍ seizures

Hema/Lymphatic-❒Neg

No Yes
❍ ❍ easy bleeding
❍ ❍ petechiae/easy bruising

Psychiatric--❒Neg

No Yes
❍ ❍ anxiety

❒ All Negative

MEDICAL HISTORY: Please check any of the following conditions which YOU have had or presently have:

❒Anemia
❒Chest Pain
❒Arthritis
❒Asthma
❒BPH
❒Cancer-Type:_____
_____
_____
❒CVA (Stroke)
❒Chronic UTIs
❒Congestive Heart Failure
❒COPD
❒Coronary Artery Disease
❒Depression
❒Diabetes
❒Diverticular disease
❒GERD
❒Gout
❒Hepatitis C
❒Hyperlipidemia
❒High Blood Pressure
❒Inflammatory bowel
❒Liver disease
❒Migraine Headaches
❒Heart Attack
❒Osteoporosis
❒Parkinson's Disease
❒Peptic Ulcer disease
❒Peripheral Vascular Disease
❒Renal/Kidney disease
❒Seizure disorder
❒Thyroid disease
❒Kidney stones
❒Valvular Heart Disease

♀ **FEMALES ONLY: Date of last Menstrual Period:** _____/_____/_____ **Date of last PAP Smear:** _____/_____/_____ ♀

Number o Pregnancies:_____ **Number of Deliveries:**_____

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

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

	Yr		Yr		Yr	♀ Females Only	Yr	♂ Males Only	Yr
❒Adrenalectmy		❒Cystoscopy		❒Kidney removed					
❒Appendectmy		❒ESWL		❒Pacemaker		❒Bladdr suspnsn		❒Brachytherapy	
❒Back Surgery		❒Gastic bypass		❒Kidney Stone Surgery		❒Hysterectomy		❒Circumcision	
❒Bladder Augumentn		❒Hernia repair		❒Ureteral Stents Plcd		❒Vaginal Sling		❒Hernia Repair	
❒CABG		Type:				❒Ovaries removed		❒Hydrocelectomy	
❒Gall Bladder								❒Laser of Prostate	
❒Bladder removal		❒Laparoscopy		**Other:**				❒Orchiectomy	
		❒Lithotripsy		❒				❒Penile Prosthesis	
				❒				❒Prostate Biopsy	
				❒				❒Prostatectomy	
								❒Spermatocelectomy	
								❒TURP	
								❒Varicocele ligation	
								❒Vasectomy	

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
Blood disease					High Cholesterol			
BPH					High Blood Pressure			
Cancer					Inflammatory bowel disease			
Type:					Migraines			
CVA / Stroke					Renal Disease			
Coronary artery disease					Renal failure			
Cardiovascular Disease					Seizure disorder			
Diabetes					Thyroid disorder			
Eczema					Urinary tract infections			
Gout					Kidney stones			
Hearing Impairment					**Other:**			
Other:								

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: _____

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: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____

☐ **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**

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.

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