Urology Associates of Norwalk, PC MEDICAL HISTORY FORM

place label here

					The state of the s			
REASON FOR VISIT (check all that apply)								
Prostate			Mass/Cyst		Kidney Stones			
Blood in Urine		Incont	inence		ED			
Other:								
	HOSSIN PARTIES	MANUFACT VICTORIA				TO SERVICE STATE	SH (SEE SHIP)	
Have you had any the following recently?					CT C			
Blood work		X-rays			CT Scans		1	
If yes, where and when?								
and the state of t	And Landon					14-15-15-A-0-0-7		
Best number to call with lab/test results:							ILLENGT ALTERNATION	
Call:	Home:			Work:				
Cell:	110	inc.						
EMERGENCY CONTACT INFORMATIO	N		MARITAL STATUS: (circle o	ne): M S D	W		
EMERGENCI CONTACT IN CHIMATIC	A AND HOLD RATE						No. of the Control of	
Name:			Number:					
Heme								
PRIMARY / REFERRING PHYSICIAN NA	AME:							
Telephone:			Fax:	Fax:				
PHARMACY NAME::								
ADDRESS:								
	MUNICIPAL TO	NONE						
	ALLERGIES (check all that apply) NONE:				Sulfa		Т	
	Aspirin Penicillin							
	Codeine Iodine				Latex			
Other:								
WAT ANY PREMISE CURCERIES			LIST ALL MEDICATION	ONS CITI	PRENTLY TAKING		Valence and	
LIST ANY PREVIOUS SURGERIES	A (1989) 116,12		LIST ALL WEDICATIO	ONS CO	KKENTET TAKING	(\$2500) (\$400) (\$100)	A 12 To String String	
DEDCONAL		Company of Control						
PERSONAL Do you use tobacco?	Yes	No	Do you drink alcohol?			Yes	No	
If yes, how much?	103	110	If yes, how much	Bo you arrive and				
Are you pregnant?	l		Due Date?					
			Duc Bute.					
Are you nursing?			Weight:				I	
Height:			Weight.					
FAMILY HISTORY								
	Yes	No				Yes	No	
Heart Disease			Bleeding Disord					
High Blood Pressure			Prostate Cancer	r				
Asthma			Lung Cancer					
Kidney Failure			Breast Cancer					
Stroke			Colon Cancer					
Diabetes			Ovarian Cancer					
				D				
Patient Signature:				Dat	e:			

Patient REVIEW OF SYSTEMS

CARDIAC					
- CANADIAG	Yes	No		Yes	No
Abnormal Heart rhythm	1		High Blood Pressure		
High Cholesterol of lipids	1		Congestive Heart Failure		
Coronary Artery Disease			Heart Valve Problems		
Heart related chest pains		· · · · · · · · · · · · · · · · · · ·	Vascular disease (low blood flow)		
Heart Attack			Other:	1	
Treat Action					
PULMONARY			RENAL (kidney)		
	Yes	No		Yes	No
Emphysema			Kidney Failure		
Asthma			Kidney Stones		
Pneumonia with last 6 weeks			Urinary Incontinence		
Diagnosed with Sleep Apnea	-		Other:		
Home Oxygen Use				1	
Tuberculosis		 		+	
Other:	-			+	
Other:		<u></u>			
HEPATIC (liver)		1	NEUROLOGIC (nervous system)		
HEPATIC (liver)	Yes	No	The state of the s	Yes	No
Liver failure	163	- 100	Seizures	 	
	-	 	Stroke (including mini strokes)		
Jaundice					
Hepatitis		-	TIA		
Other:		-	Neuropathy		
	_		Migraines		
		لــــــــا	Other:		<u></u>
			ENDOCRINE (glands)		
GI (stomach and intestines)	1 22-	1 11-	ENDOCKINE (glatius)	Yes	No
	Yes	No	L It It It a batas	1 res	INO
Frequent acid reflux or heartburn)			Insulin dependent diabetes		1
Stomach Ulcers			Non-insulin dependent diabetes		
Hiatal Hernia of the stomach			Thyroid disease		
Other:			Low		<u> </u>
			High		ļ <u>.</u>
			Other:		
			DOVOLHATOLO		
HEMATOLOGIC (blood)			PSYCHIATRIC	Yes	No
	Yes	No	Daniel and the second	+ 162	INO
Anemia		 	Depression	+	
Recent use of blood thinners			Bipolar disorder		
Bleeding or clotting disorder			Panic/anxiety attacks		
HIV or AIDS			Schizophrenia		
Other:			Other:		L
To the hest of my knowledge, the questions on th	nis form have	been accuratel	y answered. I understand that providing incorrect information o	an be danger	ous to my
(or patients) health. It is my responsibility to info	rm the medic	al office of anv	changes in medical status.	_	•
for barrenest negretti te is this temporaries to min		- · - · · · · · · · · · · · · · · · · ·	•		
	d. 4a Tha	Hunlami Assas	iates of Norwalk, PC of services rendered for me. I authorize any	, medical info	rmation

I authorize that payment of insurance benefits be made to The Urology Associates of Norwalk, PC of services rendered for me. I authorize any medical information about me be released to my insurance company or its agents as needed to determine benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any fees in collection of unpaid amounts. I allow the office to bill electronically with my signature on file in the office.

	Data
Patient signature:	Date:
raticist signature.	