

Patient Information

Patient Name		Home Address (street, city, state, zip)	
Date of Birth (mm/dd/yyyy)			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____
Home Telephone		Cell Phone	
Work Telephone		Employer and Employer Address	
Email Address			

Insurance Information

Primary Insurance Name		Address and Phone (street, city, state, zip)	
ID Number		Group Number	
Secondary Insurance Name		Address and Phone (street, city, state, zip)	
ID Number		Group Number	

Are you the primary insured person? Yes No

If no, who is the primary insured person? (skip if you are the primary insured person)

Primary Insured Name		Home Address (street, city, state, zip)	
Date of Birth (MM/DD/YYYY)			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	Relationship to Patient	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> <input type="checkbox"/> Other: _____
Cell Phone		Email Address	
Employer		Employer Phone #	



Patient Information

HIPAA Authorization to release health information to:

Name of Emergency Contact		Contact's Home Address (street, city, state, zip)	
Contact Phone			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	Relationship to Patient	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> <input type="checkbox"/> Other: _____
Release the following	<input type="checkbox"/> All records <input type="checkbox"/> Chart Notes <input type="checkbox"/> Lab Results <input type="checkbox"/> Radiology Results <input type="checkbox"/> Pathology Results		

Additional HIPAA Authorization to release health information to: (if applicable)

Name of Additional Contact		Contact's Home Address (street, city, state, zip)	
Contact Phone			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	Relationship to Patient	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> <input type="checkbox"/> Other: _____
Release the following	<input type="checkbox"/> All records <input type="checkbox"/> Chart Notes <input type="checkbox"/> Lab Results <input type="checkbox"/> Radiology Results <input type="checkbox"/> Pathology Results		

Signature

Attention: By signing, I agree that I understand and accept Integrative Urology's Terms of Service. I understand I have the right to revoke the authorizations on this form at any time by notifying Integrative Urology in writing, except to the extent that Integrative Urology has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing. My signature below authorizes communication consent and acknowledges I have been presented with Integrative Urology's Terms of Service and Notice of Privacy Practices, which can be viewed at: <http://www.inturology.com>. I can request a paper copy during my visit.

- **If the patient is 18 years of age or older**, the patient must sign and date the form
- **If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Indicate your legal authority and include documentation of your relationship:
 - Legal Guardian or Conservator Health Care Agent (Health Care Power of Attorney)
 - Other Legal Representative
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Indicate your relationship: Parent Legal Guardian

Signature (required)	Date (mm-dd-yyyy)	Time (hh:mm) <input type="checkbox"/> am <input type="checkbox"/> pm
Printed Name of Person Signing (First, Middle, Last)		

Medical History

Patient Name		Date of Birth <i>(mm/dd/yyyy)</i>	
Height <i>(ft/in)</i> Weight <i>(pounds)</i>		Occupation	
Race <i>(required CDC categories, not ours!)</i>	<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Decline to specify <input type="checkbox"/> Other:		
Ethnicity	<input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline to specify <input type="checkbox"/> Other:		
Pharmacy Name		Pharmacy Address	
Primary Care Physician (PCP)		PCP Fax #	
Referring Physician (if not PCP)		Referring Physician Fax	
Cardiologist (if any)		Cardiologist Fax #	
How did you find us?	<input type="checkbox"/> PCP <input type="checkbox"/> Friend <input type="checkbox"/> Insurance Company <input type="checkbox"/> Internet (which site?): <input type="checkbox"/> Other:		

Primary Issue: <i>(why do you want to see the doctor?)</i>	
How long have you had this issue?	<input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Other:

Current Medications (prescription drugs you are taking with dosage and schedule) See Attached List

1.	5.
2.	6.
3.	7.
4.	8.

Current Non-prescription Medications, including vitamins, supplements, aspirin, ibuprofen See Attached List

1. Aspirin? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, dose?	3.
2.	4.

Allergies (to medications, iodine, shellfish, etc) No Known Allergies See Attached List

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History (do you have any of the following) No Medical Issues

Atrial Fibrillation: <input type="checkbox"/> Yes Cancer: <input type="checkbox"/> Yes Type: _____ COPD: <input type="checkbox"/> Yes CVA/Stroke: <input type="checkbox"/> Yes	Depression: <input type="checkbox"/> Yes Diabetes: <input type="checkbox"/> Yes DVT: <input type="checkbox"/> Yes Glaucoma: <input type="checkbox"/> Yes Heart Disease: <input type="checkbox"/> Yes	Hypertension: <input type="checkbox"/> Yes Neurological Disorder: <input type="checkbox"/> Yes Osteoarthritis: <input type="checkbox"/> Yes Vascular Disease: <input type="checkbox"/> Yes Thyroid disorder: <input type="checkbox"/> Yes
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Other Medical Problems:

Medical History

Patient Name		Date of Birth (mm/dd/yyyy)	
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Prior Surgeries

Date

Family History

	Prostate Cancer or BPH	Kidney Cancer	Bladder Cancer	Kidney Stones	Urinary Tract Infections
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other?					

Social History

Current tobacco use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Former tobacco use?	<input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, how much and for how long?
Alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No. Type:
Caffeine? (cups/day)	Coffee:	Tea:	Soft Drinks: Other:

Review of Systems (have you currently or recently had)

<p>General</p> <p>Fatigue: <input type="checkbox"/> Yes</p> <p>Fever: <input type="checkbox"/> Yes</p> <p>Weight Gain: <input type="checkbox"/> Yes</p> <p>Weight Loss: <input type="checkbox"/> Yes</p> <p>Eyes</p> <p>Blurry Vision: <input type="checkbox"/> Yes</p> <p>ENT</p> <p>Dry Mouth: <input type="checkbox"/> Yes</p>	<p>Endocrine</p> <p>Cold Intolerance: <input type="checkbox"/> Yes</p> <p>Heat Intolerance: <input type="checkbox"/> Yes</p> <p>Respiratory</p> <p>Shortness of Breath: <input type="checkbox"/> Yes</p> <p>Cardiovascular:</p> <p>Chest Pain: <input type="checkbox"/> Yes</p> <p>Edema (swelling): <input type="checkbox"/> Yes</p>	<p>Gastrointestinal</p> <p>Constipation: <input type="checkbox"/> Yes</p> <p>Diarrhea: <input type="checkbox"/> Yes</p> <p>Hematology</p> <p>Bleeding Problems: <input type="checkbox"/> Yes</p> <p>Back Pain: <input type="checkbox"/> Yes</p> <p>Neurologic</p> <p>Balance Difficulty: <input type="checkbox"/> Yes</p> <p>Skin Rash: <input type="checkbox"/> Yes</p>
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Immunizations

COVID-19 vaccine: Yes No