UROLOGIC ASSOCIATES OF WESTERN PENNSYLVANIA, LTD.
PLEASE COMPLETE THE MEDICAL HISTORY FORM

NAME_____ **DATE OF BIRTH** _____ **DATE**_____

ADDRESS _____ **PHONE NUMBER** _____ **CELL NUMBER** _____

EMERGENCY CONTACT NAME _____ **RELATIONSHIP TO PATIENT** _____

EMERGENCY CONTACT PHONE NUMBER _____

PCP AND/OR PHYSICIAN WHO SENT YOU: _____

IN YOUR OWN WORDS, EXPLAIN REASON FOR YOUR VISIT _____

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? YES OR NO CUSTODIAN OF THE DOCUMENT:_____

PHARMACY: _____ **PHARMACY PHONE NUMBER:** _____
MAIL ORDER PHARMACY: _____ **PHARMACY PHONE NUMBER:** _____

MEDICATIONS: (If more lines are needed, continue on reverse)

Name of medicine (brand or generic)	Strength (mg)	Dose (# pills)	Frequency (times/day)	Timing (when taken)

Have you received:

Pneumonia Vaccine: Yes or No

Flu Vaccine: Yes or No
Month_____**Year**_____

DRUG ALLERGIES: _____ **NO DRUG ALLERGIES** _____

MEDICAL PROBLEMS (PLEASE CIRCLE **YES** IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING)

Yes ANEMIA
Yes ANGINA
Yes ANTIBIOTIC PROPHYLAXIS
Yes ATRIAL FIBRILLATION
Yes BLEEDING DISORDER
Yes CANCER
Yes DIABETES
Yes GLAUCOMA
Yes HEART ATTACK
Yes HIGH BLOOD PRESSURE
Yes SEIZURE DISORDER
Yes STROKE
Yes SEXUAL TRANSMITTED DISEASE

GYN History:
Number of Pregnancies _____

OTHER PROBLEMS: _____

_____

SURGERIES: _____

_____

FAMILY HISTORY (CIRLCE THOSE THAT APPLY)

DIABETES KIDNEY DISEASE KIDNEY STONES
HEART DISEASE CANCER DIALYSIS
OTHER_____
PROSTATE CANCER____NO_____YES - WHO?_____

SOCIAL HISTORY

SMOKER____YES
_____Quit
_____Never
How much _____

ALCOHOL_____YES
_____NO
How much _____

CAFFEINE___YES
___NO
How much _____

REVIEW OF SYSTEMS (PLEASE CIRCLE **YES** ONLY IF YOU ARE CURRENTLY EXPERIENCING THE FOLLOWING)

Yes FEVER
Yes BLURRED VISION
Yes HEARING LOSS
Yes CHEST PAIN
Yes SHORTNESS OF BREATH
Yes SLEEP APNEA
Yes CONSTIPATION
Yes INCONTINENCE
Yes BACK PAIN
IF YES PAIN SCALE LEVEL 1-10 _____
Yes RASH
Yes DIZZINESS
Yes DEPRESSION
Yes EXCESSIVE THIRST
Yes EASY BRUISING
Yes HIVES

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I, THE UNDERSIGNED, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UROLOGIC ASSOCIATES OF WESTERN PENNSYLVANIA FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIANS OR THEIR EXTENDERS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CONTRACT.

SIGNATURE_____ **DATE**_____

MEDICARE LIFETIME SIGNATURE ON FILE

I REQUEST THAT AUTHORIZED MEDICARE PAYMENT BE MADE EITHER TO ME OR ON MY BEHALF TO UROLOGIC ASSOCIATES OF WESTERN PENNSYLVANIA FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIANS OR THEIR EXTENDERS.

SIGNATURE_____ **DATE**_____