

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 BLEEDING DISORDER	Yes HEART ATTACK	Yes SEXUAL TRANSMITTED DISEASE
Yes ANGINA	Yes CANCER	Yes HIGH BLOOD PRESSURE	
Yes ANTIBIOTIC PROPHYLAXIS	Yes DIABETES	Yes SEIZURE DISORDER	GYN History:
Yes ATRIAL FIBRILLATION	Yes GLAUCOMA	Yes STROKE	Number of Pregnancies _____

OTHER PROBLEMS: _____

SURGERIES: _____

FAMILY HISTORY (CIRCLE THOSE THAT APPLY)

DIABETES _____ KIDNEY DISEASE _____ KIDNEY STONES _____
 HEART DISEASE _____ CANCER _____ DIALYSIS _____
 OTHER _____
 PROSTATE CANCER _____ NO _____ YES - WHO? _____

SOCIAL HISTORY

SMOKER _____ YES _____ NO _____
 _____ 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 CONSTIPATION	Yes DEPRESSION
Yes BLURRED VISION	Yes INCONTINENCE	Yes EXCESSIVE THIRST
Yes HEARING LOSS	Yes BACK PAIN	Yes EASY BRUISING
Yes CHEST PAIN	IF YES PAIN SCALE LEVEL 1-10 _____	Yes HIVES
Yes SHORTNESS OF BREATH	Yes RASH	
Yes SLEEP APNEA	Yes DIZZINESS	

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** _____