

ATLANTIC COAST UROLOGY, PA

ADULT AND PEDIATRIC
UROLOGY AND GENITOURINARY SURGERY

PATIENT HISTORY

WELCOME TO OUR PRACTICE

As a new patient, please fill out the information found below to the best of your ability. A few minutes of your time carefully answering the following questions will help our urologist accurately access your problem, give better care and assist in proper insurance submission.

Patient# _____ Physician _____ Today's Date _____

Patient Name _____ Age _____ Date of Birth _____

Chief Complaint (reason for visit) _____

HISTORY OF PRESENT ILLNESS

Location _____ (Where is problem or pain?) Quality _____ (Example abnormal color, sharp, dull or constant, etc.)

Severity _____ (How severe is problem or pain on a scale of 1-10, 10 being the most severe) Duration _____ (When did problem or pain start?)

Timing _____ (Does problem or pain occur at a specific time? after activity, eating, etc.) Context _____ (Where & what were you doing at onset of problem or pain?)

Associated Signs & Symptoms _____ Modifying Factors _____

(What other associated problems have you been having?)

(What makes problem or pain worse or better?)

PATIENT MEDICAL & SOCIAL HISTORY

PATIENT MEDICAL HISTORY: Have you ever had the following (circle "yes" or "no", leave blank if uncertain):

Measles	Yes No	Arthritis	Yes No	Mitral Valve Prolapse	Yes No	Blood or Plasma	
Mumps	Yes No	Venereal Disease	Yes No	Hernia	Yes No	Transfusions	Yes No
ChickenPox	Yes No	Anemia	Yes No	Asthma	Yes No	High or Low	
Whooping Cough	Yes No	Bladder Infection	Yes No	AIDS or HIV+	Yes No	Blood Pressure	Yes No
Scarlet Fever	Yes No	Epilepsy	Yes No	Stroke	Yes No	ANY OTHER DISEASES (please list)	
Diphtheria	Yes No	Hepatitis	Yes No	Ulcer	Yes No	_____	
Smallpox	Yes No	Tuberculosis	Yes No	Thyroid Disease	Yes No	_____	
Pneumonia	Yes No	Diabetes	Yes No	Kidney Disease	Yes No	_____	
Rheumatic fever	Yes No	Cancer	Yes No	DATE OF LAST CHEST		DATE OF LAST MAMMOGRAM (female)	
Heart Disease	Yes No	Polio	Yes No	X-RAY		_____	

Do you have any artificial joints, heart valves, heart pacemaker or defibrillator? _____

MEDICATIONS: (Include prescription, nonprescription and dosages) _____

ALLERGIES: (Include allergies to medication, Iodine, X-ray contrast material, shellfish, etc.) _____

PAST SURGERY: (Include date of surgery) _____

PATIENT SOCIAL HISTORY:

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco: Never: _____ Previously, but quit _____ Current packs/day: _____
Use of Drugs: Never: _____ Type/Frequency _____

What is your occupation? (If retired, what was it prior to retirement?) _____

FAMILY MEDICAL HISTORY:

AGE	DISEASE(s)	IF DECEASED CAUSE OF DEATH
Father _____		
Mother _____		
Siblings _____		
Spouse _____		
Children _____		

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever Yes No
Chills Yes No
Headache Yes No
Other _____

Gastrointestinal

Abdominal pain Yes No
Nausea/vomiting Yes No
Indigestion/heartburn Yes No
Other _____

Genitourinary

Urine retention Yes No
Painful urination Yes No
Urinary frequency Yes No
Other _____

Eyes

Blurred vision Yes No
Double vision Yes No
Pain Yes No
Other _____

Cardiovascular

Chest pain Yes No
Varicose veins Yes No
High blood pressure Yes No
Other _____

Respiratory

Wheezing Yes No
Frequent cough Yes No
Shortness of breath Yes No
Other _____

Allergic/Immunologic

Hay Fever Yes No
Drug Allergies Yes No
Other _____

Integumentary

Skin rash Yes No
Boils Yes No
Persistent itch Yes No
Other _____

Hematologic/Lymphatic

Swollen glands Yes No
Blood clotting problem Yes No
Other _____

Neurological

Tremors Yes No
Dizzy spells Yes No
Numbness/tingling Yes No
Other _____

Musculoskeletal

Joint pain Yes No
Neck pain Yes No
Back pain Yes No
Other _____

Psychologic

Memory loss/confusion Yes No
Anxiety Yes No
Depression Yes No
Other _____

Endocrine

Excessive thirst Yes No
Too hot/cold Yes No
Tired/sluggish Yes No
Other _____

Ear/Nose/Throat/Mouth

Ear infection Yes No
Sore throat Yes No
Sinus Problem Yes No
Other _____

I authorize release of information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims of insurance benefits.

X

Patient (or Guardian) Signature

Date

ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem or improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We realize there is always room for improvement! It is our policy to listen to our employees and our patients. If you feel your privacy has been compromised in any way, please ask to speak with our compliance officer or express your concern to your physician.

Please read the following "Notice of Privacy." After reading, sign and return this form to the receptionist. If you have any questions, please ask. Thank you.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that the personal health information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those we feel are in need of your health care information. **We strive to provide the best health care that is in your best interest.**

We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our compliance officer and it will be documented in your chart. If there is any party that is not directly connected to your treatment, payment, or health care operations that you would like to have your PHI released to, please fill in their name(s) and relationship in the section below.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our compliance officer. You have the right to review our entire privacy policy manual upon request. Please sign this form to acknowledge that you have read this patient notice of privacy.

Persons authorized to receive information

Relationship _____

Relationship _____

Patient Name: _____

Signature: _____ Date: _____

If minor, signature of parent or guardian: _____

Thank you for being one of our highly valued patients.

For office use only

A "good faith effort" was made to get a signature from patient, guardian, caretaker. Signature was not attained due to the following: _____