Amarillo Urology Associates, LLP

PATIENT DEMOGRAPHIC INFORMATION

DATE: _____

NAME _____ **SSN:** _____
LAST FIRST MI

DOB _____ **AGE** _____ **MALE** ☐ **FEMALE** ☐ **MARITAL STATUS:** MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ PARTNER ☐

ADDRESS: _____
STREET CITY, STATE ZIP

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

EMAIL ADDRESS: _____ **PREFERRED CONTACT METHOD:** HOME PHONE ☐ CELL PHONE ☐ TEXT ☐ WORK PHONE ☐ EMAIL ☐

EMERGENCY CONTACT _____
NAME PHONE NBR RELATION

ETHNICITY _____ **PREFERRED LANGUAGE** _____

EMPLOYER _____ **OCCUPATION** _____

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

INSURANCE INFORMATION:

INSURANCE CARRIER _____ POLICY # _____

GROUP # _____ GROUP NAME _____

POLICY HOLDER INFO:

NAME _____ DOB _____ SSN _____

CURRENT UROLOGY ISSUE (main reason for today's visit) _____

PREFERRED PHARMACY _____
NAME **LOCATION**

LAB We perform prostate screening and low testosterone labs in-house. All other labs will be sent to **PPL, LabCorp, BSA, or NWTH.** If your insurance requires you to use a specific lab, please indicate below and notify the clinical staff assisting you and a written order form will be given to you to take to the lab of your choice.

INS REQUIRED LAB _____

PREFERRED OUTSIDE IMAGING CENTER: PREFERRED IMAGING ☐ OPEN AIR MRI ☐ NWTHS ☐ BSA ☐ ADVANCED IMAGING ☐
**ALL IMAGING WILL BE PERFORMED IN-HOUSE WHEN AVAILABLE

CARE TEAM: PRIMARY CARE PHYSICIAN _____

CARDIOLOGIST _____ NEPHROLOGIST _____

OBGYN _____ ONCOLOGIST _____

PULMONOLOGIST _____ ENDOCRINOLOGIST _____

DRUG ALLERGIES:

DRUG NAME	TYPE OF REACTION

CURRENT MEDICATIONS: (if you have an updated list, please provide to the staff for a copy)

DRUG NAME	DOSAGE	DIRECTIONS

If more room is needed, please use the back.

CURRENT FLU SHOT? YES ☐ NO ☐ WHEN ADMINISTERED? _____

CURRENT PNEUMONIA SHOT? YES ☐ NO ☐ WHEN ADMINISTERED? _____

LOCATION OF PROBLEM: ABDOMEN ☐ KIDNEY ☐ PELVIS ☐ BACK ☐ GENITALIA ☐ OTHER ☐

HOW LONG DOES THE PROBLEM LAST? 15 MINS ☐ 30 MINS ☐ 1 HOUR ☐ OTHER ☐

DESCRIPTION OF PAIN: DULL ☐ SHARP ☐ DULL THEN SHARP ☐ SHARP THEN GONE ☐

ONSET DATE OF PROBLEM? _____

FAMILY HISTORY: MEDICAL ISSUES:

FATHER: LIVING? YES ☐ CURRENT AGE ____ CANCER YES ☐ NO ☐ LOCATION _____
NO ☐ AGE DECEASED ____ OTHER _____

MOTHER: LIVING? YES ☐ CURRENT AGE ____ CANCER YES ☐ NO ☐ LOCATION _____
NO ☐ AGE DECEASED ____ OTHER _____

OF BROTHERS: ____ AGES OF THOSE LIVING ____ ____ ____ ____ AGES AT TIME OF DEATH ____ ____ ____ ____
MEDICAL ISSUES: _____

OF SISTERS: ____ AGES OF THOSE LIVING ____ ____ ____ ____ AGES AT TIME OF DEATH ____ ____ ____ ____
MEDICAL ISSUES: _____

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TOBACCO USE: NEVER USED ANY TOBACCO PRODUCTS: ☐

CIGARETTES/CIGARS: FORMER SMOKER ☐ CURRENT EVERY DAY SMOKER ☐ CURRENT SOME DAY SMOKER ☐

HOW MUCH: 1 PPW ☐ 2 PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1 ½ PPD ☐ 2 PPD ☐ 3+ PPD ☐

SMOKELESS TOBACCO: FORMER USER ☐ SNUFF USER ☐ CHEWS TOBACCO ☐

HOW MUCH: 1 PER DAY ☐ 2-4 PER DAY ☐ 5+ PER DAY ☐

E-CIGARETTES/VAPE: FORMER USER ☐ CURRENT USER ☐

OF YEARS OF TOBACCO USE: _____ HAS SMOKED SINCE AGE: _____

PARTICIPATED IN A SMOKING CESSATION PROGRAM? YES ☐ NO ☐ WHEN? _____

SOCIAL HISTORY:

OCCUPATION _____ **MARITAL STATUS** MARRIED ☐ SINGLE ☐ DIVORCED ☐

EDUCATION LEVEL < 8TH ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 2 YEAR ☐ 4 YEAR ☐ POST GRADUATE ☐

WIDOWED ☐ SEPARATED ☐ PARTNER ☐

ALCOHOL INTAKE: NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY ☐

CAFFEINE INTAKE: NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY ☐

ILLICIT DRUGS: YES ☐ NO ☐ **IV DRUG USE:** YES ☐ NO ☐

DOES THE PATIENT HAVE AN ADVANCED DIRECTIVE? YES ☐ NO ☐

SURGICAL PROCEDURES: List all past surgical procedures and the year they were performed

PATIENTS AGE 50 & OVER: HAVE YOU HAD A COLONOSCOPY? YES ☐ NO ☐ WHEN: _____

PROCEDURE	DATE	PROCEDURE	DATE

PAST MEDICAL HISTORY:

CONDITION	YES	NO	CONDITION	YES	NO
BLEEDING DISORDER			HEART DISEASE		
CANCER			HIGH BLOOD PRESSURE		
DIABETES			HIGH CHOLESTROL		
DIVERTICULITIS			KIDNEY STONES		
EMPHYSEMA			SEIZURES		
ENLARGED PROSTATE			STROKE		
HIV/HEPATITIS					

Do you now have or have you had any problems related to the following areas in the last year:
Please explain any YES answers in the space provided

Constitutional:
- Fever Y N
- Chills Y N
- Headache Y N
- Other:_____

Eyes:
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other_____

Immunologic (Allergy):
- Hay Fever Y N
- Drug Allergies Y N
- Other_____

Neurologic:
- Tremors Y N
- Dizziness Y N
- Numbness Y N
- Tingling Y N
- Other_____

Endocrine:
- Excessive Thirst Y N
- Too hot/Too cold Y N
- Tired/Sluggish Y N
- Other_____

Gastrointestinal:
- Abdominal Pain Y N
- Nausea/Vomiting Y N
- Indigestion/Heartburn Y N
- Other_____

Cardiovascular:
- Chest Pain Y N
- Varicose Veins Y N
- High Blood Pressure Y N
- Other_____

Integumentary (Skin):
- Skin Rash Y N
- Boils Y N
- Persistent Itch Y N
- Other_____

Musculoskeletal:
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Other_____

Ears/Nose/Throat/Mouth
- Ear Infection Y N
- Sore Throat Y N
- Other_____

Genitourinary:
- Urinary Retention Y N
- Urinary Frequency Y N
- Painful Urination Y N
- Blood in Urine Y N
- Other_____

Respiratory:
- Wheezing Y N
- Frequent cough Y N
- Shortness of Breath Y N
- Other_____

Hematologic/Lymphatic:
- Swollen Glands Y N
- Blood Clotting Y N

Other_____

Psychologic:
- Satisfied with Life Y N
- Severely Depressed Y N
- Considered Suicide Y N
- Other_____