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 (only if card not available):

INSURANCE CARRIER __________________________________ POLICY # ___________________________

GROUP # _______________________ GROUP NAME ____

POLICY HOLDER INFO (required, unless same as patient): RELATION TO PT ____________________________

NAME _______________________________ DOB _______________ SSN _______________________

GUARANTOR INFO (required for minors): RELATION TO PT ____________________________

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:

CARDIOLOGIST ________________________ NEPHROLOGIST ___________________________

OBGYN ______________________________ ONCOLOGIST _____________________________

PULMONOLOGIST _______________________ ENDOCRINOLOGIST ________________________

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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? ____________________

COVID VACCINATION? 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 ☐ ORGAN ____________
NO ☐ AGE DECEASED ____ OTHER ____________________

MOTHER: LIVING? YES ☐ CURRENT AGE ____ CANCER YES ☐ NO ☐ ORGAN ____________
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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SOCIAL HISTORY:

EMPLOYED? NO ☐ YES ☐ **EMPLOYER** ____________________

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 ☐

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? ____________

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			MENTAL HEALTH DISORDER		
ENLARGED PROSTATE			SEIZURES		
HIV/HEPATITIS			STROKE		

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Please mark any symptoms that you are currently experiencing today.

CONSTITUTIONAL:	☐ FEVER ☐ NIGHT SWEATS ☐ WEIGHT GAIN _____ lbs ☐ WEIGHT LOSS ____ lbs ☐ EXERCISE INTOLERANCE ☐ SEDATION ☐ LETHARGY ☐ CHILLS ☐ MALAISE
CARDIOVASCULAR:	☐ CHEST PAIN ON EXERTION ☐ ARM PAIN ON EXERTION ☐ SHORTNESS OF BREATH WHILE WALKING ☐ SHORTNESS OF BREATH WHEN LYING DOWN ☐ PALPITATIONS ☐ KNOWN HEART MURMUR ☐ LIGHT-HEADED ON STANDING ☐ ANKLE SWELLING
RESPIRATORY:	☐ COUGH ☐ WHEEZING ☐ SHORTNESS OF BREATH ☐COUGHING UP BLOOD ☐ SLEEP APNEA
GASTROINTESTINAL:	☐ ABDOMINAL PAIN ☐ NAUSEA ☐ VOMITTING ☐ CONSTIPATION ☐ CHANGE IN APPETITE ☐ BLACK OR TARRY STOOLS ☐ FREQUENT DIARRHEA ☐ VOMITING BLOOD ☐ DYSPEPSIA ☐ GERD
GENITOURINARY:	☐ URINARY LOSS OF CONTROL ☐ DIFFICULTY URINATING ☐ INCREASED URINARY FREQUENCY ☐ HEMTURIA ☐ INCOMPLETE EMPTYING
MUSCULOSKELETAL:	☐MUSCLE ACHES ☐MUSCLE WEAKNESS ☐ARTHRALGIAS/JOINT PAIN ☐BACK PAIN ☐CRAMPS ☐ SWELLING IN THE EXTREMITIES ☐ NECK PAIN ☐ DIFFICULTY WALKING ☐ OSTEOPOROSIS ☐ FRACTURES
SKIN:	☐ ABNORMAL MOLE ☐ JAUNDICE ☐ RASH ☐ ITCHING ☐ DRY SKIN ☐ GROWTHS/LESIONS ☐ LACERATIONS ☐ NON-HEALING AREAS ☐ CHANGES IN HAIR/NAILS ☐ PSORIASIS ☐ CHANGE IN SKIN COLOR ☐ BREAST LUMP
NEUROLOGIC:	☐LOSS OF CONSCIOUSNESS ☐WEAKNESS ☐NUMBNESS ☐SEIZURES ☐DIZZINESS ☐ PARALYSIS ☐ FREQUENT OR SEVERE HEADACHES ☐ MIGRAINES ☐ RESTLESS LEGS ☐ TREMOR ☐ GAIT DYSFUNCTION
PSYCH:	☐ DEPRESSION ☐ SLEEP DISTURBANCES ☐FEELING UNSAFE IN RELATIONSHIP ☐RESTLESS SLEEP ☐ ALCOHOL ABUSE ☐ ANXIETY ☐ HALLUCINATIONS ☐ MOOD SWINGS ☐ MEMORY LOSS ☐ AGITATION ☐ DEMENTIA ☐ DELIRIUM
ENDOCRINE:	☐ FATIGUE ☐ INCREASED THIRST ☐ HAIR LOSS ☐ INCREASED HAIR GROWTH ☐ COLD INTOLOERANCE
HEMATOLOGIC/LYMPHATIC:	☐ SWOLLEN GLANDS ☐ EASY BRUISING ☐ EXCESSIVE BLEEDING ☐ ANEMIA ☐ PHLEBITS