

Patient History Form

Today's Date ____/____/____

Note: This is a confidential record and will be kept in your physician's office.
Information contained herein will not be released to anyone
without your authorization.

Date of Last
Physical Exam ____/____/____

Last Name _____ First Name _____ Middle _____

Social Security No. _____ Date of Birth ____/____/____ Family Physician _____

Chief Complaint—What is the main reason for your visit today? Please describe your problem in detail.

History of Present Illness— Please answer the following questions.

Location of the Problem

Abdomen Back Leg Genitals  Front Back

Other _____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other _____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other _____

How long does the problem last?

30 minutes 1 hour It is always there

Other _____

Is anything else occurring at the same time?

Yes No If yes, please explain

Nausea Rash Headaches

Other _____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Does the problem interfere with your normal functions? Y N
If yes, please explain _____

Other _____

Past Medical and Social History—

Please list all serious illnesses in your immediate family. (Examples: diabetes, tuberculosis, breast cancer, heart disease, etc...)

If Tuberculosis, confirmation of cure date _____ Smoking? Y- # packs____N Alcohol: Y- frequency____N

Please list any **personal past illnesses** and /or surgeries and when they occurred. _____

Are you on any medications? If yes, please list all medications: _____

Do you have allergies? Y or N If yes, please list all.

Physician's Use Only (comments/Notes)	# Answers	Level of Service
	0	1 or 2
	1—2	3
	3	4—5

Review of Systems

Last Name _____

First Name _____

Do you now have or have you experienced any problems related to the following systems during the last six months?
Circle **Yes** or **No**.

<p>Constitutional Symptoms</p> <p>Fever Y N</p> <p>Chills Y N</p> <p>Headache Y N</p> <p>Other _____</p> <p>Eyes</p> <p>Blurred vision Y N</p> <p>Double vision Y N</p> <p>Pain Y N</p> <p>Other _____</p> <p>Allergic / Immunologic</p> <p>Hay fever Y N</p> <p>Drug allergies Y N</p> <p>Other _____</p> <p>Neurological</p> <p>Tremors Y N</p> <p>Dizzy spells Y N</p> <p>Numbness/tingling Y N</p> <p>Endocrine</p> <p>Excessive thirst Y N</p> <p>Too hot/cold Y N</p> <p>Tired/sluggish Y N</p> <p>Other _____</p>	<p>Gastrointestinal</p> <p>Abdominal pain Y N</p> <p>Nausea/vomiting Y N</p> <p>Indigestion/ heartburn Y N</p> <p>Other _____</p> <p>Cardiovascular</p> <p>Chest pain Y N</p> <p>Varicose veins Y N</p> <p>High blood pressure Y N</p> <p>Other _____</p> <p>Integumentary</p> <p>Skin rash Y N</p> <p>Boils Y N</p> <p>Persistent itch Y N</p> <p>Other _____</p> <p>Musculoskeletal</p> <p>Joint pain Y N</p> <p>Neck pain Y N</p> <p>Back pain Y N</p> <p>Other _____</p>	<p>Ear/Nose/Throat/Mouth</p> <p>Ear infection Y N</p> <p>Sore throat Y N</p> <p>Sinus problems Y N</p> <p>Other _____</p> <p>Genitourinary</p> <p>Urine retention Y N</p> <p>Painful urination Y N</p> <p>Urinary frequency Y N</p> <p>Other _____</p> <p>Respiratory</p> <p>Wheezing Y N</p> <p>Frequent cough Y N</p> <p>Shortness of breath Y N</p> <p>Other _____</p> <p>Hematological/Lymphatic</p> <p>Swollen glands Y N</p> <p>Blood clotting problems Y N</p> <p>Other _____</p> <p>Psychological</p> <p>Are you generally satisfied with your life? Y N</p> <p>Do you feel severely depressed? Y N</p> <p>Have you considered suicide? Y N</p> <p>Other _____</p>
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Physician's Use Only (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10 +	4 or 5

Provider _____ Date ____/____/____

NORTHEAST UROLOGIC SURGERY, P.C.
STEVEN R. PREVITE, MD OSSAMA E. SAKR, M.D.
LIAM J. HURLEY, M.D. GEORGE E. CANELLAKIS, M.D.
TRACEY S. WILSON, M.D. CHARLES R. BURKE, M.D.
LYNN L. LANGLOIS, PA-C

PATIENTS'S NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ MALE: _____ FEMALE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE:(HOME) _____ WORK: _____ CELL: _____

MARRIED: _____ SINGLE: _____ SEPARATED: _____ DIVORCED: _____ WIDOWED _____

FAMILY PHYSICIAN: _____ REFERRED BY: _____

PATIENT EMPLOYED BY: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ TELEPHONE: _____

SPOUSE NAME: _____

SPOUSE EMPLOYED BY: _____

BUSINESS ADDRESS: _____ TELEPHONE: _____

NAME OF CLOSEST RELATIVE/FRIEND WHO DOES NOT LIVE WITH YOU: _____ TELEPHONE: _____

RESPONSIBLE PERSON'S NAME: _____ SOCIAL SECURITY # _____

ADDRESS: _____

STREET CITY STATE ZIP CODE

PATIENT'S RELATIONSHIP TO RESPONSIBLE PERSON SELF SPOUSE CHILD

OTHER _____

LIST ALL INSURANCE PLANS PRIMARY AND SECONDARY

MEDICARE OR PRIMARY INSURANCE NAME: _____

MEDICARE OR PRIMARY INSURANCE ADDRESS: _____

POLICYHOLDER LAST NAME: _____ FIRST NAME: _____

RELATIONSHIP: _____

CERTIFICATE # _____ GROUP# _____ MEMBER# _____

MEDICARE OR SECONDARY INSURANCE NAME: _____

MEDICARE OR 2ndary INSURANCE ADDRESS: _____

POLICYHOLDER LAST NAME: _____ FIRST NAME: _____

RELATIONSHIP: _____

CERTIFICATE # _____ GROUP# _____ MEMBER# _____

PERMISSION FOR TEST RESULTS: Person designated below to be given test results if I cannot be contacted,

NAME: _____ HOME PHONE _____ WORK PHONE _____

AUTHORIZATION:

Authorization to pay benefits. I hereby authorize payment directly to Northeast Urologic Surgery, PC for services rendered, realizing I am responsible to pay any balance not paid or not covered by my insurance company.

I hereby authorize Northeast Urologic Surgery, PC to release any information necessary to process insurance claims.

PATIENT _____ Date: _____

IF YOUR INSURANCE REQUIRES A SPECIFIC LAB FOR ALL STUDIES PLEASE INFORM US.

Northeast Urologic Surgery, P.C.

HIPAA PRIVACY PRACTICES

We have a legal duty to protect health information about you.

We may use and disclose Protected Health Information or “PHI” about you in the following circumstances:

- We may use and disclose PHI about you to provide health care treatment to you.
- We may use and disclose PHI about you to obtain payment for services.
- We may use and disclose your PHI for health care operations.
- We may use and disclose PHI under other circumstances without your authorization, such as when required by law or for public health activities.
- You can object to certain uses and disclosures.
- We may contact you to provide appointment reminders.
- We may contact you with information about treatment, services, products or health-care providers.
- We may contact you for fundraising activities.

Any other use or disclosure of PHI about you requires your written authorization.

You have the following rights regarding PHI about you.

- You have the right to request restrictions on uses and disclosures of PHI about you.
- You have the right to request different ways to communicate with you.
- You have the right to see and copy PHI about you.
- You have the right to request amendment of PHI about you.
- You have the right to a listing of disclosures we have made.
- You have a right to a copy of this notice.
- You may file a complaint about our privacy practices.

For additional information regarding privacy practices, contact the Office Manager.

This Notice of Privacy Practices is effective as of today’s date: _____

Patient’s Name:

Parent/Guardian Signature:

**NORTHEAST UROLOGIC SURGERY , PC
PATIENT AUTHORIZATION FORM**

HIPPA regulations set by the Federal Government requires that we have a signed authorization on file from you each year. The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We need this record to provide you with quality care and to comply with certain legal requirements. Please review our Privacy Document and Your Rights located in our office. A copy is available upon request. Please inform us of the following information:

I, _____ hereby authorize Northeast Urologic Surgery, PC to convey or release medical information to the following. *PLEASE INITIAL THE FOLLOWING CHOICES:*

_____ *For continuity of medical care information may be given to referring physicians, physician assistants, nurses, qualified medical staff involved in my care*

_____ I authorize release of medical information to my insurance company and payment of benefits to Northeast Urologic Surgery, P.C. and for continuity of my care

_____ I authorize use of medical interpreters for the continuity of my care

_____ I authorize use of appointment confirmation with messages left on my answering machine or another family member

_____ I authorize release of medical information to my family or to a specific family member or friend named here: _____

_____ I authorize medical information to:

Patient to Fill In _____

(Disaster Relief, Funeral Directors, Medical Examiner, Courts, Public Health Activities, Victims of Abuse/ Neglect/Domestic Violence, Worker's Compensation, Health Oversight Activities, Law Enforcement, etc)

THIS DOES NOT COVER SENSITIVE INFORMATION

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law.

I understand that I may inspect or copy the information used or disclosed.

I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that

a. Action has been taken in reliance on this authorization

b. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to consent a claim under the policy.

I understand Northeast Urologic Surgery, P.C. will honor my rights of confidentiality in a reasonable and safe manner within the dictates of their practice policies.

Signed

Date