For Office Use Only:

MRN#: \_\_\_\_\_\_\_\_\_\_\_

**Legal Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ **SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex:** M / F **Primary Care Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City ST Zip Code

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_ **Insurance Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City ST Zip Code

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party if Different:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit:**

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_ Urinary Tract Infection | \_\_ Blood in Urine | \_\_ Low Sexual Desire | \_\_ Pain with Urination |
| \_\_ Difficulty Urinating | \_\_ Frequent Urination | \_\_ Discharge | \_\_ Elevated PSA |
| \_\_ Prostate Problems | \_\_ Strong Urge to Urinate | \_\_ Testicular Pain | \_\_ Other: |
| \_\_ Kidney Mass | \_\_ Urine Leakage | When does it occur?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_ Elevated PSA | \_\_ Weak Urine Stream | How long has this been going on?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_ Difficulty with Erections | \_\_ Urinating at Night | Does anything make it better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Do you have any of the following?**

|  |  |  |
| --- | --- | --- |
| Y or N Fever or Chills | Y or N Cough | Y or N Back Pain |
| Y or N Fatigue | Y or N Shortness of Breath | Y or N Nipple Discharge |
| Y or N Headaches | Y or N Nausea | Y or N Bleeding Problems |
| Y or N Weight Loss | Y or N Vomiting | Y or N Depression |
| Y or N Changes in Vision | Y or N Constipation | Y or N Anxiety |
| Y or N Sore Throat | Y or N Diarrhea | Y or N Pain During Sex |
| Y or N Chest Pain | Y or N Abdominal Pain |  |

**Past Medical History/Illness: (Check all that apply)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_ Asthma | \_\_ Blood Clots | \_\_ Heart Attack | \_\_ Gout | \_\_ Blood/Bleeding Problems |
| \_\_ High Blood Pressure | \_\_ Kidney Disease | \_\_ Stroke | \_\_ Heart Failure | \_\_ High Cholesterol |
| \_\_ Liver Disease (Hepatitis) | \_\_ Vascular Disease | \_\_ Seizures | \_\_ HIV/AIDS | \_\_Stomach Ulcers |
| \_\_ Rheumatoid Arthritis | \_\_ Thyroid Disorder | \_\_ Diabetes | \_\_ Cancer, Type/Stage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Past Surgery: (Check all that apply)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_ Heart Bypass | \_\_ Tubal Ligation | \_\_ Hernia | \_\_ Bowel Surgery | \_\_ Appendectomy |
| \_\_ Prostate | \_\_ Joint Replacement | \_\_ Fractures | \_\_ Gallbladder Removal | \_\_ Hysterectomy |
| \_\_ Tendon/Ligament Repair | \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  |

Turn Page Over

**Social History: (Circle Y or N)**

Do you smoke? **Y / N** How much: \_\_\_\_\_\_\_\_ Have you ever smoked? **Y / N** How much: \_\_\_\_\_\_\_\_

Do you consume alcohol? **Y / N** How much: \_\_\_\_\_\_\_\_ Employment Status: **working**, **retired**, **disabled** Job: \_\_\_\_\_\_\_\_

Relationship Status: **single**, **married**, **divorced**, **widowed** Have Kids: **Y / N**

**Circle Below:**

Mother: Deceased (Yes or No) Age of death \_\_\_\_\_\_\_\_ Cause of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: Deceased (Yes or No) Age of death \_\_\_\_\_\_\_\_\_ Cause of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: Who in your family has the following? (Please write M for Mother, F for Father)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_\_ Asthma | \_\_\_\_ Diabetes | \_\_\_\_ Heart Attack | \_\_\_\_ High Cholesterol | \_\_\_\_ Glaucoma |
| \_\_\_\_ COPD | \_\_\_\_ Kidney Failure | \_\_\_\_ Stroke | \_\_\_\_ High Blood Pressure | \_\_\_\_ Vascular Disease |
| \_\_\_\_ Bladder Cancer | \_\_\_\_ Kidney Cancer | \_\_\_\_ Prostate Cancer |  |  |

**What pharmacy do you use?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your medications and doses below: (Include any nonprescription medications)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any medications?** Yes or No

**Please list medication allergies and your reaction: Nausea / itching / hives / difficulty breathing / other**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any allergy to:** Iodine **Y / N** Metal **Y / N**  Latex **Y / N**

**Authorization, Assignment of Benefits, and Referral Medical Release:**

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly o Columbus Regional Health Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Request for Treatment:**

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by the physicians of the nature and purpose of an proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you!