EFFINGHAM UROLOGY ASSOCIATES SC
Patient Information Sheet

Date:	Chart #:	Referring Physician:	Age:
Patient Name:			Marital Status:
Mailing Address:	City:	State:	Zip:
Home Phone:	Birthdate:	SS #:	
Parents (if pt is a minor):			
Is Child Covered under Parents Insurance?		Is there any Secondary Insurance?	

Employer Information

Employer:			Employer Phone:
Employer Address:	City:	State:	Zip:

Spouse Information

Name:		Address:	
SS #:	Birthdate:	Employer:	
Employer Address:			Phone:
*In Case of Emergency Contact:			Phone:

Insurance Information:
Do you have Medicare? ____________________
On the job Injury? ____________________
(If yes, complete worker's comp form)

Do you have Medicaid? ____________________
Motor Vehicle Accident? ____________________
(If yes, complete MVA form)

Insurance Co.:			Insurance Co.:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		
Policyholder:			Policyholder:		
Policy #:			Policy #:		
ID #:			ID #:		

Do we have permission to release medical information to family members? ____________________ (Specify)

I understand that my primary insurance will be filed, and if no payment is made within 45 days, I will be responsible for the balance.

I hereby authorize Effingham Urology as a holder of Medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claims(s). If further request payment be made to Effingham Urology and authorize the Center to submit claims on my behalf for a bills or services furnished to me during the next 12-month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my inusrance carrier. If this accouunt is placed in the hands of collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

PERMISSION TO TREAT: I hereby give Effingham Urology permission to evaluate and treat the above named patient.

____
Date

____
Signature of Patient, or If Minor, parent/guardian

PATIENT HISTORY FORM

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

TODAY'S DATE_____/_____/_____ DATE OF LAST PHYSICAL EXAM_____/_____/_____

LAST NAME____________________ FIRST NAME____________ MIDDLE____________

Social Security No. ____________ DATE OF BIRTH_____/_____/_____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

____

____

____

History of Present Illness

Please answer the following questions

Location of the problem

Abdomen Back Leg

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

Other______________________

Does the problem interfere with your normal functions?

YES No If yes, please explain____________

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery **Date**

____

Do you smoke? Y N

If yes, how much? ____________

Do you drink? Y N

If yes, how much? ____________

Are you on any medications? Y N (If yes, list all.)

____

Are you on a special diet? Y N (If yes, please explain)

____

Do you have allergies? Y N (If yes, Please explain.)

____

Physician use only: (Comments/Notes)

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

(OVER)

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Review of Systems

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

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other________		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other________		

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other________		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other________		

Endocrine

Excessive thirst	Y	N
Too hot/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 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________		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other________		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	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 problem	Y	N
Other________		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other________		

Physician use only: (Comments/Notes)

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

Physician: ________________________ Date: ____/____/____

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