WESTSIDE UROLOGICAL MEDICAL GROUP

M.J. Kelly, M.D. Peter M. Loisides, M.D.

Introductory MALE Medical Review

Your Name: _____ **Today's Date:** ___/__/___

Referring Physician: Dr._____

Nature of Presenting Illness:

Chief Complaint: (Why are you HERE today?)

_____

_____

Duration of Condition: _____ Days / Weeks / Months / Years
Quality of Symptoms: on and off / continuous / getting: better /worse/stable
Severity of Condition: mild / moderate / severe

Past Medical/Surgical History:

General Urological Survey:

1. Has their been a change in your voiding pattern? ___Yes ___No
2. Have you ever been screened for Prostate Cancer? ___Yes ___No
3. Have you experienced Erectile Dysfunction? ___Yes ___No
4. Have you noticed blood in the urine or semen? ___Yes ___No
5. Have you ever had Male Infertility problems? ___Yes ___No
6. Have you ever had a Urinary Tract Infection? ___Yes ___No
7. Have you ever had a Sexually Transmitted Disease? ___Yes ___No
8. Have you ever had a Kidney Stone? ___Yes ___No

Genera Medical Survey:

1. List Prior Major Illnesses and Injuries:

   _____

   _____

2. List Prior Surgeries:

   _____

   _____

3. List Prior Hospitalizations:

   _____

   _____

4. Current Medications:

   _____ _____

   _____ _____

5. Allergies to Drugs, Foods, Materials, etc.:

   _____

   _____

Social History:

Marital Status and/or Living Arrangement: _____

Current Employment: _____

Occupational History: _____

_____

Use of Drugs, Alcohol, Tobacco: _____

Highest Level of Education: _____

Sexual History: Heterosexual / Bi-Sexual / Homosexual

Review of Systems:

(Circle Appropriate Symptoms)

General:	weight loss/gain fever chills weakness
Eyes:	blurred vision eye pain double vision
Ears, Nose &Throat:	hearing loss ringing in ears ear infection nasal congestion sinus infection hoarseness
Cardiovascular:	chest pain palpitations high blood pressure swollen ankles
Respiratory:	shortness of breath wheezing cough sputum
Gastrointestinal:	jaundice nausea vomiting diarrhea constipation bloody stools abdominal pain
Musculoskeletal:	arthritis muscular weakness/atrophy bone pain
Skin/Breast:	rash ulcerations lumps itchiness hair loss
Neurological:	dizziness tremors weakness loss of sensation tingling
Psychiatric:	depression anxiety agitation suicidal tendencies
Endocrine:	excessive thirst too hot/cold tired/sluggish decreased libido
Blood/Lymphatic:	bruising bleeding tendency swollen glands
Allergy:	hay fever latex allergy food allergy drug allergy

Westside Urological Medical Group

Patient Registration DATE: / /

Please PRINT and Complete ALL Sections

Last Name: First Name M.I.

Street Address: Apt. #

City: State Zip

Home Telephone ( ) Work/Daytime Phone: ( )

Date of Birth / / Age Sex: M / F

Marital Status: Single Married Divorced Widowed Other

Social Security # - - Driver's License # State

Your Employer: Occupation:

Address: City State ZIP

Spouse's Name: Daytime Phone: ( )

Responsible Party:

Resp.Party's Home telephone: ( ) Work ( )

Resp. Party's Home Address:

City State Zip

Employer:

Address: City State Zip

Occupation:

Patient Insurance Information: (Please present insurance cards to receptionist)

Primary Insurance:

Co. Name: ( )

Claims Address:

City State Zip

Name of Insured: D.O.B.

Relationship of patient to insured: { }SELF { }SPOUSE { }PARENT { }CHILD

Certificate /Policy # Group #

Annual Deductible? $ Met This Year?

Office Copayment? HMO PPO MEDICARE Indemnity Private

Secondary Insurance:

Co. Name: ( )

Claims Address:

City State Zip

Name of Insured: D.O.B.

Certificate/Policy # Group #

Annual Deductible? $Met This Year?

Office Copayment? HMO PPO MEDICARE Indemnity Private

Physician by Whom You Were Referred?

Telephone # ( ) Fax ( )

Names of Other Physicians Who Care For You:

(Please Continue on Reverse Side)

Who May We Contact To Reach You In Case of an Emergency? (Name of Person Not Living With You):

Relationship: _____

Telephone #'s: Home ( )_____ Work/Daytime: ( )_____

Address: _____

City _____ State _____ ZIP _____

Assignment of Benefits / Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Mark J. Kelly, MD/Peter M. Loisides, MD and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance or should my coverage for health plan benefits not be in effect at the time services are rendered. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees. I hereby authorize Mark J. Kelly, MD/Peter M. Loisides, MD to release all information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient's Signature: _____ Date: _____

Responsible Party (If Patient is a Minor): _____