

Patient Information

| Date of Birth (mm/dd/yyyy) Gender | Patient Name | | Home Address (street, city, state, zip) | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|-----------------------------------------|-----------------------------------------|--|--|--|
| Maile Female Status Single Married Divorced Widowed | | | | | | | |
| Other: Status Other: | | □ Male □ Female | Marital | ☐ Single ☐ Married ☐ Divorced ☐ Widowed | | | |
| Telephone Employer and Employer and Employer and Employer Address Insurance Information Address and Phone (street, city, state, zip) ID Number Group Number Address and Phone (street, city, state, zip) ID Number Group Number Group Number Secondary Insurance Name Group Number Insurance Name Group Number ID Number Home Address (street, city, state, zip) If no, who is the primary insured person? (skip if you are the primary insured person) Primary Insured Name Home Address (street, city, state, zip) Date of Birth (MM/DD/YYYY) Gender Male Female Relationship to Patient Other: Cell Phone Email Address Relationship to Patient Other: Cell Phone Email Address Address Relationship to Patient Other: Cell Phone Email Address Address Relationship to Patient Other: Cell Phone Email Address Address Relationship to Patient Other: Cell Phone Email Address Address Cell Phone Email Address Cell Phone Cell Phone Cell Phone Cell Phone | | ☐ Other: | Status | _ | | | |
| Work Telephone | | | Cell Phone | | | | |
| Telephone and Employer Address | • | | | | | | |
| Email Address Insurance Information | | | | | | | |
| Email Address Insurance Information | Telephone | | | | | | |
| Insurance Information | | | | | | | |
| Insurance Information Primary Insurance Name Address and Phone (street, city, state, zip) ID Number Secondary Insurance Name Address and Phone (street, city, state, zip) ID Number Group Number Are you the primary insured person? Yes No If no, who is the primary insured person? (skip if you are the primary insured person) Primary Insured Name Home Address (street, city, state, zip) Date of Birth (MM/DD/YYYY) Gender | | | Address | | | | |
| Primary Insurance Name Address and Phone (street, city, state, zip) | | | | | | | |
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| Name (street, city, state, zip) | • | | | | | | |
| State, zip) State, zip) State, zip) Secondary Number Address Address and Phone (street, city, state, zip) St | | | | | | | |
| ID Number Group Number Address and Phone (street, city, state, zip) | Name | | , | | | | |
| Number Secondary Insurance Name Address and Phone (street, city, state, zip) | | | State, Zip) | | | | |
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| State, zip) | | | | | | | |
| ID Number Group Number Are you the primary insured person? Yes No If no, who is the primary insured person? (skip if you are the primary insured person) Primary Insured Name Date of Birth (MM/DD/YYYY) Gender Male Female Relationship to Patient Spouse Parent Guardian Other: To Patient Other: To Patient Address | Name | | | | | | |
| Are you the primary insured person? | | | state, zip) | | | | |
| Are you the primary insured person? | ID Number | | Group | | | | |
| Primary Home Address (street, city, state, zip) Date of Birth (MM/DD/YYYY) Gender | | | | | | | |
| Primary Insured Name Date of Birth (MM/DD/YYYY) Gender | | • | | pary insured person) | | | |
| Date of Birth (MM/DD/YYYY) | | , , , , | | , | | | |
| Date of Birth (MM/DD/YYYY) Gender | | | Home Addres | s (street, city, state, zip) | | | |
| (MM/DD/YYYY) Relationship to Patient Spouse Parent Guardian Other: Cell Phone Email Address | ilisuleu Naille | | | | | | |
| (MM/DD/YYYY) Relationship to Patient Spouse Parent Guardian Other: Cell Phone Email Address | | | | | | | |
| (MM/DD/YYYY) Relationship to Patient Spouse Parent Guardian Other: Cell Phone Email Address | | | | | | | |
| Cell Phone Email Address | | | | | | | |
| Cell Phone Email Address | Gender | ☐ Male ☐ Female | • | ☐ Spouse ☐ Parent ☐ Guardian | | | |
| Address | | ☐ Other: | to Patient | Other: | | | |
| Address | Cell Phone | | Email | | | | |
| Employer Employer | | | | | | | |
| | Employer | | Employer | | | | |



Patient Information

| ΗΙΡΔΔ | Authorizat | ion to | rolosso | health | inform | ati∧n | to: |
|-------|-------------------|--------|---------|--------|----------|-------|-----|
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| Name of Emergency Contact | | Contact's Home Address (street, city, state, zip) | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------|--------------------|------------------------|--|--|--|
| Contact Phone | | | | | | | |
| Gender | ☐ Male ☐ Female ☐ Other: | Relationship to Patient | ☐ Spouse ☐ Other:_ | | | | |
| Dalagas tha | | | | | | | |
| Release the following | ☐ All records ☐ Chart Notes ☐ Lab Result: | s □ Radiology F | Results □ Patho | ology Results | | | |
| Additional HIP | AA Authorization to relea | ase health in | formation to | o: (if applicable) | | | |
| Name of | | Contact's Hor | ne Address (str | eet, city, state, zip) | | | |
| Additional | | | (| , , , , , , | | | |
| Contact | | | | | | | |
| Contact Phone | | | | | | | |
| Gender | ☐ Male ☐ Female | Relationship | ☐ Spouse ☐ | Parent □ Guardian | | | |
| | ☐ Other: | to Patient | Other: | | | | |
| Release the | ☐ All records | | | | | | |
| following | ☐ Chart Notes ☐ Lab Result | s □ Radiology F | Results □ Patho | ology Results | | | |
| Signature | | | | | | | |
| Attention: By signing, I agree that I understand and accept Integrative Urology's Terms of Service. I understand I have the right to revoke the authorizations on this form at any time by notifying Integrative Urology in writing, except to the extent that Integrative Urology has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing. My signature below authorizes communication consent and acknowledges I have been presented with Integrative Urology's Terms of Service and Notice of Privacy Practices, which can be viewed at: http://www.inturology.com. I can request a paper copy during my visit. If the patient is 18 years of age or older, the patient must sign and date the form If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may signa dn date the form. Indicate your legal authority and include documentation of your relationship: □ Legal Guardian or Conservator □ Health Care Agent (Health Care Power of Attorney) □ Other Legal Representative If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Indicate your relationship: □ Parent □ Legal Guardian | | | | | | | |
| Signature (require | ed) | Date | (mm-dd-yyyy) | Time (hh:mm)) □ am | | | |
| | | | | □ pm | | | |
| Printed Name of | Person Signing (First, Middle, | Last) | | | | | |



Medical History

| Patient Name | | | | Date of Birth | | | | | |
|---------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------|--------------|-----------------------|-------------------|-----------|--|--|--|
| Halada (ft/in) | | | | (mm/dd/yyyy) | | | | | |
| Height (ft/in) Weight (pounds) | | | | Occupation | | | | | |
| Race | │ | | | | | | | | |
| (required CDC | | U WITHE D ASIAN D AIRCAN AIRCIDAN D WIDGE EASIENT OF NORTH AIRCAN | | | | | | | |
| categories, not ours!) | ☐ Decline to specify ☐ Other: | | | | | | | | |
| Ethnicity | ☐ Not Hispani | c or Latino □ Hispa | nic or Latin | o □ Decline to sp | ecify Other: | | | | |
| Pharmacy Name | | | | Pharmacy Address | | | | | |
| Primary Care | | | | PCP Fax # | | | | | |
| Physician (PCP) | | | | | | | | | |
| Referring Physician | | | | Referring | | | | | |
| (if not PCP) | | | | Physician Fax | | | | | |
| Cardiologist (if any) | | | | Cardiologist Fax # | | | | | |
| How did you find | | end □ Insurance Co | mnany □ I | l. | -2)· | | | | |
| us? | | | inpany — i | memet (which sit | o : | | | | |
| | ☐ Other: | | | | | | | | |
| | | | | | | | | | |
| Primary Issue: | | | | | | | | | |
| (why do you want to | | | | | | | | | |
| see the doctor?) | | | | | | | | | |
| How long have you | │ □ □ □ □ We | eks □ Months □ V | ears □ Oth | ner: | | | | | |
| had this issue? | B Days B We | □ Days □ Weeks □ Months □ Years □ Other: | | | | | | | |
| Current Medications (| prescription drug | s you are taking wit | h dosage a | ınd schedule) 🗆 S | See Attached List | | | | |
| 1. | | | 5. | | | | | | |
| 2. | | | 6. | | | | | | |
| 3. | | | 7. | | | | | | |
| 4. | | | | | | | | | |
| | | | 8. | | | | | | |
| Current Non-prescript | ion Medications | s, including vitamins, | , suppleme | nts, aspirin, ibupro | ofen □ See Attac | ched List | | | |
| 1. Aspirin? ☐ No ☐ Yes. If yes, dose? | | | | 3. | | | | | |
| 2. | | | 4. | | | | | | |
| Allergies (to medications, iodine, shellfish, etc) □ No Known Allergies □ See Attached List | | | | | | | | | |
| | | | | | | | | | |
| History (do you have a | ny of the followin | g) 🛘 No Medical Is | ssues | | | | | | |
| Atrial Fibrillation: 🗆 Y | es | Depression: | ☐ Yes | s Hyper | tension: |] Yes | | | |
| Cancer: ☐ Y | | Diabetes: | ☐ Yes | ' | logical Disorder: | | | | |
| Type: | | DVT: | ☐ Yes | | • | □ Yes | | | |
| COPD: \(\sup Y | es | Glaucoma: | ☐ Yes | | ılar Disease: | ☐ Yes | | | |
| CVA/Stroke: ☐ Y | es | Heart Disease: | ☐ Ye | Vasce | id disorder: | □ Yes | | | |
| | | 1 | | Tilylo | ia disorder. | □ 103 | | | |

Other Medical Problems:



Medical History

| Patient Name | | | | | | | Date of Birth (mm/dd/yyyy) | | |
|----------------------------|-----------------------|--------------------------------------------------------------------|----------|---------------------------|----------------|----------------|--------------------------------|-----------------------------|--|
| Prior Surgeries Date | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |
| Family History | | | | | | | | | |
| | Prosta or BP | | ancer | Kidney C | ancer | Bladder Cancer | Kidney Stones | Urinary Tract Infections | |
| Father | |] | | | | | | | |
| Mother | |] | | | | | | | |
| Grandparent | | | | | | | | | |
| Sibling | | | | | | | | | |
| Child | | | | | | | | | |
| Other? | | | | 1 | | | • | • | |
| Social History | · | | | | | | | | |
| Current tobacco use? | □ Yes □ | Yes ☐ No Former tobacco ☐ Yes ☐ No. If yes, how much and for huse? | | | | | nuch and for how long |) ? | |
| Alcohol use? | □ Yes □ | Yes □ No Other Drugs? □ Yes □ No. Type: | | | | | | | |
| Caffeine? (cups/day) | Coffee: | Coffee: Tea: | | | Soft Dr | inks: | Other: | | |
| Review of Syst | l ems (have | you c | urrently | or recently | y had) | | | | |
| General Fatigue: | ☐ Yes | ☐ Yes Cold I | | | ne lerance: | ☐ Yes | Gastrointestinal Constipation: | ☐ Yes | |
| Fever: | ☐ Yes | | | Heat Intolerance: ☐ Yes [| | Diarrhea: | ☐ Yes | | |
| Weight Gain: | | ☐ Yes☐ Respiratory | | | | Hematology | | | |
| Weight Loss: | ⊔ Yes | | | | ss of Breath: | | Bleeding Problems Back Pain: | s: □ Yes □ Yes | |
| Eyes Blurry Vision: | □ Yes | ☐ Yes Card | | | ascular: | | | □ res | |
| ENT | 30 | Chest Pa | | | 1111. | | Neurologic Balance Difficulty: | ☐ Yes | |
| Dry Mouth: | ☐ Yes | | | Lucina (| oweiling). | ш 103 | Skin Rash: | ☐ Yes | |
| mmunizations | | | | | | | | | |

COVID-19 vaccine: ☐ Yes ☐ No