INTEGRATIVE™ UROLOGY

Patient Information

Patient Name		**Home Address** (street, city, state, zip)	
Date of Birth *(mm/dd/yyyy)*			
Gender	☐ Male ☐ Female ☐ Other:__________	**Marital Status**	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:____________
Home Telephone		**Cell Phone**	
Work Telephone		**Employer and Employer Address**	
Email Address			

Insurance Information

Primary Insurance Name		**Address and Phone** (street, city, state, zip)	
ID Number		**Group 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	☐ Male ☐ Female ☐ Other:__________	**Relationship to Patient**	☐ Spouse ☐ Parent ☐ Guardian ☐ Other:__________
Cell Phone		**Email Address**	
Employer		**Employer Phone #**	

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Patient Information

HIPAA Authorization to release health information to:

Name of Emergency Contact		**Contact's Home Address** (street, city, state, zip)	
Contact Phone			
Gender	☐ Male ☐ Female ☐ Other:__________	**Relationship to Patient**	☐ Spouse ☐ Parent ☐ Guardian ☐ Other:__________
Release the following	☐ All records ☐ Chart Notes ☐ Lab Results ☐ Radiology Results ☐ Pathology Results		

Additional HIPAA Authorization to release health information to: (if applicable)

Name of Additional Contact		**Contact's Home Address** (street, city, state, zip)	
Contact Phone			
Gender	☐ Male ☐ Female ☐ Other:__________	**Relationship to Patient**	☐ Spouse ☐ Parent ☐ Guardian ☐ Other:__________
Release the following	☐ All records ☐ Chart Notes ☐ Lab Results ☐ Radiology Results ☐ Pathology 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 (required)	**Date** *(mm-dd-yyyy)*	**Time** *(hh:mm))* ☐ am ☐ pm
Printed Name of Person Signing *(First, Middle, Last)*		

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Medical History

Patient Name		**Date of Birth** *(mm/dd/yyyy)*	
Height *(ft/in)* **Weight** *(pounds)*		**Occupation**	
Race *(required CDC categories, not ours!)*	☐ White ☐ Asian ☐ African American ☐ Middle Eastern or North African ☐ Decline to specify ☐ Other:		
Ethnicity	☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to specify ☐ Other:		
Pharmacy Name		**Pharmacy Address**	
Primary Care Physician (PCP)		**PCP Fax #**	
Referring Physician (if not PCP)		**Referring Physician Fax**	
Cardiologist (if any)		**Cardiologist Fax #**	
How did you find us?	☐ PCP ☐ Friend ☐ Insurance Company ☐ Internet (which site?): ☐ Other:		

Primary Issue: *(why do you want to see the doctor?)*	
How long have you had this issue?	☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Other:

Current Medications (prescription drugs you are taking with dosage and schedule) ☐ See Attached List

1.	5.
2.	6.
3.	7.
4.	8.

Current Non-prescription Medications, including vitamins, supplements, aspirin, ibuprofen ☐ See Attached 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 any of the following) ☐ No Medical Issues

Atrial Fibrillation: ☐ Yes Cancer: ☐ Yes Type:___________________ COPD: ☐ Yes CVA/Stroke: ☐ Yes	Depression: ☐ Yes Diabetes: ☐ Yes DVT: ☐ Yes Glaucoma: ☐ Yes Heart Disease: ☐ Yes	Hypertension: ☐ Yes Neurological Disorder: ☐ Yes Osteoarthritis: ☐ Yes Vascular Disease: ☐ Yes Thyroid disorder: ☐ Yes

Other Medical Problems:

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Medical History

Patient Name		Date of Birth *(mm/dd/yyyy)*	

Prior Surgeries **Date**

Family History

	Prostate Cancer or BPH	Kidney Cancer	Bladder Cancer	Kidney Stones	Urinary Tract Infections
Father	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Grandparent	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐
Other?					

Social History

Current tobacco use?	☐ Yes ☐ No	Former tobacco use?	☐ Yes ☐ No. If yes, how much and for how long?
Alcohol use?	☐ Yes ☐ No	Other Drugs?	☐ Yes ☐ No. Type:
Caffeine? (cups/day)	Coffee: Tea: Soft Drinks: Other:		

Review of Systems (have you currently or recently had)

General	Endocrine	Gastrointestinal
Fatigue: ☐ Yes	Cold Intolerance: ☐ Yes	Constipation: ☐ Yes
Fever: ☐ Yes	Heat Intolerance: ☐ Yes	Diarrhea: ☐ Yes
Weight Gain: ☐ Yes	**Respiratory**	**Hematology**
Weight Loss: ☐ Yes	Shortness of Breath: ☐ Yes	Bleeding Problems: ☐ Yes
Eyes		Back Pain: ☐ Yes
Blurry Vision: ☐ Yes	**Cardiovascular:**	**Neurologic**
ENT	Chest Pain: ☐ Yes	Balance Difficulty: ☐ Yes
Dry Mouth: ☐ Yes	Edema (swelling): ☐ Yes	Skin Rash: ☐ Yes

Immunizations

COVID-19 vaccine: ☐ Yes ☐ No