PATIENT FOLLOW-UP FORM

UROLOGY GROUP, PA

DATE:____________________

PATIENT NAME____BIRTHDATE:____________DOCTOR:_______________

HAS YOUR ADDRESS, PHONE OR INSURANCE CHANGED? ☐ YES ☐ NO IF NO, CONTINUE TO "REASON FOR VISIT"

ADDRESS:____

CITY:____STATE:___________ZIP:____________________

TELEPHONE: HOME_________________________ CELL_________________________ WORK____________________________

INSURANCE:____SS#____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐

SPOUSE'S NAME:____NUMBER OF CHILDREN:___________

DO YOU SMOKE? YES ☐ NO ☐ IF YES, HOW MUCH? _____________________________

LIST ALLERGIES: ____

REASON FOR VISIT____

⇩⇩⇩⇩⇩⇩ SINCE YOUR LAST CHECK-UP ⇩⇩⇩⇩⇩⇩

NEW MEDICAL CONDITIONS (PLEASE LIST): WHEN? PHYSICIAN? WHERE TREATED?

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____

HAVE YOU BEEN HOSPITALIZED? **YES** ☐ **NO** ☐ **IF YES, FOR WHAT CONDITION?**

____

SURGICAL PROCEDURES (PLEASE LIST): WHEN? PHYSICIAN? WHERE TREATED?

____

____

NEW FAMILY ILLNESSES OR MEDICAL CONDITIONS (PLEASE LIST)

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____

PLEASE LIST SYMPTOMS OR CONDITIONS THAT ARE CAUSING THE MOST CONCERN:

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PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

PLEASE CHECK ANY CONDITIONS WHICH APPLY TO YOU:

HEAD	☐ NORMAL	☐ VERTIGO	☐ SINUS	☐ NOSE BLEED	☐ DIZZINESS	☐ OTHER	
RESP	☐ NORMAL	☐ SHORTNESS OF BREATH	☐ BRONCHITIS	☐ EMPHYSEMA	☐ ASTHMA	☐ OTHER	
C VASC	☐ NORMAL	☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ HEART MURMUR	☐ ARRHYTHMIA	☐ HEART VALVE DISEASE	☐ OTHER
GI	☐ NORMAL	☐ ESOPHAGEAL DISEASE	☐ ULCERS	☐ HEPATITIS	☐ CROHNS DISEASE	☐ COLITIS	☐ OTHER
PVASC	☐ NORMAL	☐ PAIN WHEN WALKING	☐ VARICOSE VEINS	☐ PHLEBITIS	☐ OTHER		
ONC/HEM	☐ NORMAL	☐ CANCER	☐ ANEMIA	☐ EASY BLEEDING	☐ SICKLE CELL	☐ BLOOD TRANSFUSION	☐ OTHER
ENDO	☐ NORMAL	☐ DIABETES	☐ THYROID DISORDER	☐ OTHER			
NEURO	☐ NORMAL	☐ STROKE	☐ MIGRAINE	☐ SEIZURES	☐ PARKINSONS	☐ OTHER	
ARTH	☐ NORMAL	☐ PAIN IN JOINTS	☐ GOUT	☐ OSTEOPOROSIS	☐ BONE FRACTURE	☐ OTHER	
DERM	☐ NORMAL	☐ RASHES	☐ HIVES	☐ ECZEMA	☐ PSORIASIS	☐ HERPES	☐ OTHER
MENTAL HEALTH	☐ NORMAL	☐ DEPRESSION	☐ SLEEP DISORDERS	☐ COLITIS	☐ OTHER		
INFECT	☐ NORMAL	☐ RHEUMATIC FEVER	☐ MUMPS	☐ MONO	☐ TUBERCULOSIS	☐ H.I.V.	☐ OTHER
FEMALES	☐ NORMAL	☐ # OF PREGNANCIES______	☐ LAST MENSTRUAL PERIOD __________	☐ BIRTH CONTROL	☐ MENOPAUSE	☐ OTHER	

AUTHORIZATION AND CONSENT

I HEREBY AUTHORIZE THAT PAYMENT FROM MY MEDICAL INSURANCE CARRIER OR MY Medicare benefits be made directly to the Urology Group, P.A. on any unpaid bills for services provided on or any time after today. In addition, I authorize any holder of medical or other information about me to release to the Health Care Finance Administration, its intermediaries, insurance companies or agents, any information needed to determine benefits payable for services. I also permit a copy of this consent and authorization to be used in place of the original.

I understand that I am financially responsible for any balance not covered by my insurance carrier or managed care company.

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PATIENT NAME (PLEASE PRINT)

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PATIENT SIGNATURE