BROWARD UROLOGY
Eliecer Kurzer, M.D., M.P.H.
Michael Simon, M.D.
1951 SW 172 Ave., Suite 300
Miramar, Florida 33029
Tel (954) 499-7696 | Fax (954) 499-7699
www.browardurology.com

PLEASE PRINT CLEARLY

Email address: ____________________

TODAY'S DATE: __________

LAST NAME: __________ FIRST NAME: __________ MIDDLE INITIAL: ___

ADDRESS: ____________________ APT #: __________

CITY: ____________________ STATE: ______ ZIP: __________

HOME #: __________ CELL #: __________ WORK #: __________

PCP DOCTOR ____________________ PCP NUMBER ____________________

CAN WE LEAVE MESSAGES, RESULTS, APPT CONFIRMATION MESSAGES AT THE ABOVE NUMBERS:

PLEASE CIRCLE HOME: YES NO CELL: YES NO WORK: YES NO

PATIENT PHARMACY NUMBER FOR FUTURE MEDICATIONS ____________________

SS#: __________ DOB: __________ AGE: ______ SEX: ____

MARITAL STATUS (circle one): SINGLE MARRIED WIDOWED DIVORCED

EMERGENCY CONTACT NAME ____________________ NUMBER ____________________

EMPLOYER: ____________________

EMPLOYER'S ADDRESS: ____________________

CITY: ____________________ STATE: ______ ZIP: __________

INSURANCE INFORMATION

IS CONDITION: WORK-RELATED: ____________________ DATE OF INJURY: __________

AUTO ACCIDENT: ____________________ DATE OF INJURY: __________

NAME OF ATTORNEY
RERESENTING PATIENT: ____________________ PHONE #: __________

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
NAME OF INSURED: __________	NAME OF INSURED: __________
INS CO. NAME: __________	INS CO. NAME: __________
ADDRESS: __________	ADDRESS: __________
CITY: __________ ST: ____ ZIP: ______	CITY: __________ ST: ____ ZIP: ______
PHONE: __________	PHONE: __________
POLICY#: __________	POLICY#: __________
GROUP #: __________	GROUP #: __________

FINANCIAL AGREEMENT:
I AUTHORIZE THE RELEASE OF ANY PAYMENT AND MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND RELATED CLAIMS.

I ALSO UNDERSTAND THAT I AM FINCANCIALLY RESPONSIBLE FOR THOSE CHARGES NOT PAID FOR BY MY INSURANCE COMPANY.

I ALSO UNDERSTAND IF THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR OUR ATTORNEY, ALL FEES WILL BE THE RESPONSIBILITY OF THE PATIENT/GUARANTOR.

SIGNATURE: ____________________ DATE: __________

Assignment of Benefits/Right to Payment, Patient Responsibility and Release of Information Form

21st Century Oncology, LLC
Broward Urology
PO BOX 86215 ORLANDO, FL 32886-2152

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

______________________________ Date: ______________________

Signature of Patient/Person Legally Responsible

____

Print Name of Patient/Person Legally Responsible

____

Relationship to Patient
(If signed by Person Legally Responsible)

21st Century Oncology, LLC
Broward Urology

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

______________________________ ______________________
Signature of Patient or Representative Date

____
Print Name

****

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: ______________________________

Date of attempt to obtain acknowledgment: ______________________

Reason acknowledgment was not obtained:

- ☐ Patient/family member received notice but refused to sign acknowledgment
- ☐ Emergency treatment situation
- ☐ Patient was incapacitated and no family member was present
- ☐ Unable to communicate due to language barriers
- ☐ Other (please describe below)

____
____

______________________________ ______________________
Signature of Employee Date

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number
Address (Street, City, State, ZIP Code)		Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I **authorize** the names listed below to have access to my medical Information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	**Relationship to Patient**

*DO NOT discuss or provide information to the following individuals or entities:

Restricted Name/Entity	**Relationship to Patient**

*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

____

____

____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient

____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted __________ Denied __________

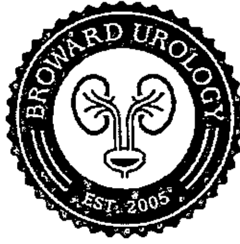
*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable ______________________________

____

____

Physician Office Representative: Date:



Eliecer Kurzer, M.D., M.P.H
Michael Simon, M.D.

Cancellation Policy/No Show Policy
For Doctor Appointments and In-office procedures

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty dollar ($20) cash fee; THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.
If a patient is 15 minutes past their scheduled time we may have to reschedule the appointment.

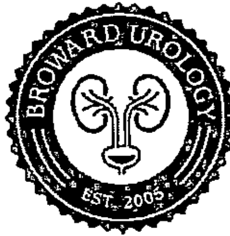
3. ***All account balances are due at time of service***

Patients who have questions about their bills may call our office billing department at 786-999-6509 whom they can review their account and concerns.

______________________	______________________	___/___/___
Print Name Patient	**Signature Patient/Guardian**	**Date**

___/___/___
DOB
Patient Account #________________
(Office Use Only)

BROWARD UROLOGY
1951 SW 172 AVE., SUITE 300, MIRAMAR, FL 33029
TEL: 954.499.7696 FAX: 954.499.7699 NURSES STATION FAX: 954.251.5293



Eliecer Kurzer, M.D., M.P.H
Michael Simon, M.D.

Broward Urology
Patient Chart Portal Access

Date: ______________________________

Patient Name: ___________________________DOB: _____________________

Dear patient.

In order to have access to your Broward Urology Patient Portal, we require the following information.

Please PRINT your personal email address: ______________________________________

Please provide a user name of your choosing: _____________________________________

Once your information is entered, an email will be sent to you with instructions on how to log in to.

https://patientportal.intrinsiq.com/1038

Please maintain this information in a private safe place. You will be prompted to change your password again in order to gain access. Should you have any questions please feel free to contact us.

Messages and requests sent to your doctor's office are NOT monitored 24/7.
If you are experiencing a medical emergency, you should call 911 immediately.
Results will not be review under the Patient Portal; you must follow up for results.

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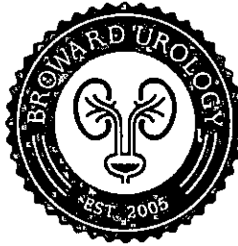

Eliecer Kurzer, M.D., M.P.H
Michael Simon, M.D.

Notice

This is a private area. You are not authorized to conduct any audio or video recordings on this premises. It is unlawful to conduct any such recordings on this premises under Fla. Stat. § 934.03.

Language to add to consent form:

"By signing hereto, you acknowledge your understanding that I [________________________________] does not consent to any audio or video recordings on its premises, and (ii) it is unlawful to conduct any audio or video recordings on this premises under Florida law (pursuant to Fla. Stat. § 934.03). Additionally, by signing hereto you further acknowledge that you will not conduct any audio or video recordings.

______________________ ______________

Patient Name DOB

______________________ ______________

Patient Signature Date

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Notice of Privacy Practices
21st Century Oncology, LLC
Broward Urology

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

Our Responsibilities
We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures - How we may use and disclose protected health information about you

For Treatment: We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment: We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:

- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

Law Enforcement / Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Notice of Privacy Practices (Page 2)
21st Century Oncology, LLC
Broward Urology

Other Uses of Your Protected Health Information That Require Your Authorization
Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at www.21stcenturyoncology.com.

Changes to This Notice
We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679-8944, or by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

For further information, contact:
Privacy Officer
2270 Colonial Boulevard
Fort Myers, FL 33907
1-866-679-8944

Name: ______________________________ **Date:** ____________________

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods):

____

____

____

____

____

Recent Foreign Travel:

None: ______ Americas: ____________________ Worldwide: ____________________

CURRENT MEDICATIONS:

Please list ALL medications you are currently taking including over the counter meds

Drug Name	Strength	Directions/How you take it

(Attach list if necessary)

Pharmacy Name: ______________________________ **Phone #** ____________________

By what method did you choose our practice?

_____ Referring Physician _____ Friend _____ Yellow Pages _____ Insurance Co. _____ Other

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PATIENT'S NAME: ______________________________ **DATE:** ____________

REVIEW OF SYSTEMS: (Please place a '✓' by all that apply)

Allergic/Immunologic
- ____ Seasonal
- ____ Drug
- ____ Animal
- ____ Environmental
- ____ Other

Cardiovascular
- ____ Chest pain/angina
- ____ Dyspnea on exertion
- ____ Edema
- ____ Hardening of the arteries
- ____ Heart Attack
- ____ Heart Failure
- ____ Heart Murmur
- ____ High Blood Pressure
- ____ Irregular Heart beat
- ____ Low exercise tolerance
- ____ Mitral Valve Prolapse
- ____ Orthopnea
- ____ Pain/cramps w/exercise
- ____ Palpitations
- ____ Skipped Heart beats
- ____ Swelling
- ____ Other

Constitutional
- ____ Aches/Pains
- ____ Appetite Changes
- ____ Bruises easily
- ____ Fever
- ____ Chills
- ____ Hot Flashes
- ____ Night Sweats
- ____ Fatigue
- ____ Generalized Weakness
- ____ Insomnia
- ____ Swollen Glands
- ____ Anorexia
- ____ Weight loss
- ____ Weight gain
- ____ Other

Ears/Nose/Throat
- ____ Ear Infection
- ____ Sinus Problems
- ____ Sore Throat
- ____ Other

Endocrine
- ____ Diabetes
- ____ Pituitary Disease
- ____ Thyroid Disease
- ____ Excess thirst
- ____ Tired/Sluggish
- ____ Heat/Cold Intolerance
- ____ Other

Eyes
- ____ Blindness
- ____ Blurred Vision
- ____ Double Vision
- ____ Eye Pain
- ____ Other

Gastrointestinal
- ____ Acid Reflux
- ____ Indigestion/Heartburn
- ____ Nausea/Vomiting
- ____ Abdominal Pain
- ____ Bloody Stools
- ____ Abdominal Cramps
- ____ Diarrhea
- ____ Constipation
- ____ Change in Bowel Habits
- ____ Hemorrhoids
- ____ Flatulence
- ____ Gas
- ____ Rectal Bleeding
- ____ Tarry stools
- ____ Other

Genitourinary
- ____ Back Pain
- ____ Bedwetting
- ____ Blood in urine
- ____ Dribbling
- ____ Burning on Urination
- ____ Erection Problems
- ____ Premature Ejaculation
- ____ Flank Pain
- ____ Hesitancy
- ____ Kidney Failure
- ____ Kidney Infections
- ____ Kidney Stones
- ____ Nocturnal Enuresis
- ____ Nocturia
- ____ Prostate Infection
- ____ Sexual Dysfunction
- ____ Low desire
- ____ Sexually Transmitted Diseases
- ____ Stranguria
- ____ Suprapubic Pain
- ____ Testes/Scrotal Swelling
- ____ Urgency
- ____ Urinary Frequency
- ____ Urinary Hesitancy
- ____ Urinary Incontinence
- ____ Urinary Tract Infections
- ____ Urine Retention
- ____ Urologic Cancer
- ____ Urologic Surgery
- ____ Vaginal Bleeding
- ____ Vaginal Discharge/Problems
- ____ Weak Stream
- ____ Other

Hematological/Lymphatic
- ____ Swollen Glands
- ____ Blood clotting problems
- ____ Bleeding Problems
- ____ Hepatitis
- ____ HIV (AIDS)
- ____ IV Drug Use
- ____ Sickle Cell
- ____ Other

Musculoskeletal
- ____ Back Pains
- ____ Joint Pains
- ____ Neck pain /stiffness
- ____ Muscle Cramps
- ____ Arthritis
- ____ Muscle Weakness
- ____ Other

Neurological
- ____ Stroke
- ____ Headache
- ____ Dizzy spells
- ____ Balance problems
- ____ Numbness/Tingling
- ____ Tremors
- ____ Leg or arm weakness
- ____ Memory Loss
- ____ Speech Problems
- ____ Other

Psychological
- ____ Not satisfied with life
- ____ Anxious
- ____ Depressed
- ____ Considered Suicide
- ____ Other

Respiratory
- ____ Asthma
- ____ Tuberculosis
- ____ Emphysema/Bronchitis
- ____ Environmental Allergies
- ____ Frequent Cough
- ____ Shortness of Breath
- ____ Wheezing
- ____ Other

Skin
- ____ Acne
- ____ Boils
- ____ Persistent Itch
- ____ Skin rash
- ____ Changing moles
- ____ Pigment changes
- ____ Other

Name: ______________________ **Date:** __________

PAST MEDICAL HISTORY

Please place a '✓' by any of the following diseases or conditions you have or have had:

- ___ ADD
- ___ ADHD
- ___ Alcoholism
- ___ Allergies
- ___ Alzheimer's Disease
- ___ Anemia
- ___ Aneurysm
- ___ Angina
- ___ Anorexia
- ___ Anxiety Disorder
- ___ Arthritis
- ___ Arrhythmia
- ___ Aortic aneurysm
- ___ Aortic Stenosis
- ___ Aortic Insufficiency
- ___ Asthma
- ___ Atrial fibrillation
- ___ Back pain
- ___ BPH
- ___ Bi-polar disorder
- ___ Bladder Cancer
- ___ Bleeding Disorder
- ___ Blindness
- ___ Brain tumors
- ___ Breast Cancer
- ___ Bronchitis
- ___ Cataracts
- ___ Cerebrovascular Disease
- ___ Cholecystitis
- ___ Cholelithiasis
- ___ Chronic fatigue syndrome
- ___ Chronic liver disease
- ___ Chronic lung disease
- ___ Chronic renal insufficiency
- ___ Chronic Renal Failure
- ___ Colitis
- ___ Constipation
- ___ Colon Cancer
- ___ Colon Condition
- ___ Congenital Heart Disease
- ___ Congenital Heart Failure
- ___ Crohn's Disease
- ___ Deafness
- ___ Deep vein thrombosis
- ___ Depression
- ___ Diabetes—non ins dependent
- ___ Diabetes—insulin dependent
- ___ Diabetes—uncontrolled
- ___ Diarrhea
- ___ Eating Disorder
- ___ Ear Infections
- ___ Elevated PSA
- ___ Emphysema
- ___ Enlarged Heart
- ___ Epilepsy
- ___ Fibrocystic Breast Disease
- ___ Fibromyalgia
- ___ Gastric Cancer
- ___ GERD
- ___ Glaucoma
- ___ Goiter
- ___ Gout
- ___ Hay Fever
- ___ Heart Attack
- ___ Heart Disease
- ___ Heart Valve Problem
- ___ Heart Murmur
- ___ Hemorrhoids
- ___ Hepatitis
- ___ Herniated Disc
- ___ Hiatal Hernia
- ___ High Cholesterol
- ___ High Blood pressure
- ___ Impaired Glucose
- ___ Infertility
- ___ Irritable Bowel Disease
- ___ Inflam. Bowel Disease
- ___ Kidney Disease
- ___ Kidney Infection
- ___ Kidney stones
- ___ Infectious Disease
- ___ Laryngeal Cancer
- ___ Leukemia
- ___ Liver Disease
- ___ Lung Disease
- ___ Lung Cancer
- ___ Lymphoma
- ___ Melanoma
- ___ Mental Illness
- ___ Migraine
- ___ Mitral stenosis
- ___ Mitral insufficiency
- ___ Mitral Valve Prolapse
- ___ Mumps
- ___ Nervous Breakdown
- ___ Obesity
- ___ Osteoporosis
- ___ Pancreatitis
- ___ Pancreatic Cancer
- ___ Peptic Ulcer
- ___ Phlebitis
- ___ Polio
- ___ tol. Prostate Cancer
- ___ Prostatitis
- ___ Pulmonary embolism
- ___ Rectal Fissure
- ___ Rectal Cancer
- ___ Rheumatic Fever
- ___ Sexually Trans. Disease
- ___ Sickle Cell Anemia
- ___ Stroke
- ___ Suicide Attempt
- ___ Testicular Cancer
- ___ Thyroid Disease
- ___ Tuberculosis

SURGICAL HISTORY:

Please **place a '✓'** by any of the following surgeries you have had, and **include the date of surgery**:

Amputation	______	Facial Surgery	______	Orchiectomy	______
Angioplasty	______	Foot Surgery (L or R or both)	______	Pacemaker Insertion	______
Aortic Aneurysm Repair	______	Gastric Surgery	______	Parathyroidectomy	______
Appendectomy	______	Hand Surgery (L or R or both)	______	Penile Implant	______
Arthroscopic Surgery	______	Heart Surgery	______	PEG	______
Back Surgery	______	Heart Transplant	______	Renal Transplant	______
Bariatric Surgery	______	Hemorrhoidectomy	______	Rotator Cuff Surgery	______
Bladder Surgery	______	Herniorrhaphy	______	Septoplasty	______
Bowel Resection	______	Hip Surgery	______	Sinus Surgery	______
Brachytherapy	______	Hydrocelectomy	______	Skin Grafting	______
Brain Surgery	______	Ilioconduit	______	Spermatocelectomy	______
Breast Surgery	______	Ileostomy	______	Splenectomy	______
Biopsy of Prostate	______	Indigo Laser Surgery	______	Stomach Surgery	______
CABG	______	Inguinal Herniorrhaphy	______	Tonsil Surgery	______
Carotid Artery Surgery	______	Knee Surgery (L or R or both)	______	Thyroid Surgery	______
Carpal Tunnel Surgery (L or R or both)	______	Laminectomy	______	TMJ Surgery	______
Cataract Surgery (L or R or both)	______	Laparoscopy	______	TUMT Prostate	______
Cervical Spine Surgery	______	Laparatomy	______	TUR Prostate	______
Cholecystectomy	______	Leg Surgery (L or R or both)	______	Umbilical Hernia	______
Circumcision	______	Liver Surgery	______	Ureteroscopy	______
Colon Resection	______	Lumpectomy	______	Varicocelectomy	______
Colonoscopy	______	Lung Surgery	______	Vasectomy	______
Corneal Surgery (L or R or both)	______	Lymphatic Node Dissection	______	Vein Stripping	______
Cysto-TUR Fulguration	______	Lysis Adhesions	______	Ventral Hernia Repair	______
Cyst Removal	______	Mastectomy	______	VLAPP	______
Deliveries (Vaginal or C-Section)	______	Mastoid Surgery	______	**OTHER NOT LISTED :**	
Ear Surgery (L or R or both)	______	Meatotomy	______		______
EGD	______	Nasal Surgery	______		______
Epididymectomy	______	Needle Biopsy	______		______
ESWL	______	Nephrectomy	______		______
Eye Surgery (L or R or both)	______	Nephrolithotomy	______		

NAME: ______________________ Date: ______________

FAMILY HISTORY

Please **CIRCLE** which family member has had any of the following: (Mother, Father, or Siblings)

Arthritis	M	F	S	Kidney Stones	M	F	S
Bedwetting	M	F	S	Laryngeal Cancer	M	F	S
Bladder Cancer	M	F	S	Leukemia	M	F	S
Cancer (site unknown)	M	F	S	Malignant Melanoma	M	F	S
Crohn's Disease	M	F	S	Multiple Sclerosis	M	F	S
Depression	M	F	S	Pancreatic Cancer	M	F	S
Diabetes	M	F	S	Prostate Cancer	M	F	S
Gout	M	F	S	Stroke	M	F	S
Heart Attack	M	F	S	Thyroid Disease	M	F	S
Hypertension	M	F	S	Tuberculosis	M	F	S
Kidney Disease	M	F	S	Other:	M	F	S

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please **indicate years**:

Single: __________ Married: __________ Separated: __________ Divorced: __________

Widowed: __________ Life Partner: __________ Common Law Spouse: __________

Dependants: Please **indicate # of each**, if you have:

Sons: ______ Daughters: ______ Stepchildren: ______ Adopted: ______ Foster: ______

Parents: ______ Grandparents: ______ Other: __________ : ______

Occupation: Please **place a '✓'** by one that applies:

None ______ Laborer ______ Truck Driver ______ Tradesman ______

Clerk ______ Administrative ______ Executive ______ Professional ______

Part-Time ______ Retired ______ Other ______

Hobbies: Please **place a '✓'** by any that apply to you:

None ______ Golf ______ Tennis ______ Computers ______ Basketball ______

Football ______ Swimming ______ Soccer ______ Baseball ______

Alcohol Consumption:

None ______ Yes - Occasional/Social ______ # of drinks per day __________

Tobacco use per day:

None _____ Yes _____ # packs/day ______ cigarettes/day ______ smokeless tobacco ______

If previously stopped, when? ________________

Recreational Drugs:

None _______ If yes, please list: ____

____

____

____

____

____

Caffeinated beverages:

None ______ Low _______ Moderate _______ Excessive _______