**Sequoia Urology Center**

Adult and Pediatric Urology \* Male Infertility \* Impotence

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

Welcome to Sequoia Urology Center. We are pleased that you have chosen us to provide you with your medical services.

Please request your primary care or referring physician to fax to our office any pertinent medical information prior to your appointment.

Enclosed are the new patient registration forms and information. Please complete and bring with you to your appointment:

* Patient information sheet;
* Health history form;
* Consent / authorization form
* Financial policy
* **If you are unable to bring the completed forms with you, please plan on arriving 30 minutes early to finish the forms prior to your appointment time.**

Upon arrival for your appointment, we ask that you check-in with our receptionist. In addition to the completed forms you will be giving her, she will need:

* A copy of your insurance card(s);
* Photo Identification – (Due to new HIPAA/Identity Theft rules if the address is incorrect on your ID we will need a copy of a utility bill showing proof of your correct address)
* “Referral” or “authorization” form from your health plan (if required)
* Co-payments your health plan requires
* To take your picture for our electronic medical records

It is our desire to make your visit a pleasant one. If you have any questions, please ask – we want to be of assistance and look forward to meeting you.

Your appointment is scheduled at Sequoia Urology Center on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_ am / pm; in the following office location:

□ 2900 Whipple Ave

Ste. 130

Redwood City, CA 94062

Ph:(650) 362-8250 – Fax: (650) 362-9440

**SEQUOIA UROLOGY CENTER**

**Chris B. Threatt, M.D. – Marina White-Nagy, M.D.**

**Please PRINT and complete ALL sections below**

|  |
| --- |
| **REGISTRATION FORM** |
| **PATIENT'S PERSONAL INFORMATION**  **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Last Name First Name Initial**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Street City State Zip Code**  **Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security# \_\_\_\_\_\_- \_\_\_\_- \_\_\_\_\_\_ Sex: M F Marital Status: S M W D**  **Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   |  | | --- | | **If Under 18, Parent’s Name or Responsible Party)**  **Guarantor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Street City State Zip Code**  **Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  | |
| **PRIMARY INSURANCE INFORMATION** Please provide copy of insurance card  **Insurance Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Subscriber ID#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Social Security# \_\_\_\_\_\_\_- \_\_\_\_\_- \_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **SECONDARY INSURANCE INFORMATION (IF APPLICABLE)**  **Insurance Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Subscriber ID#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Social Security# \_\_\_\_\_\_\_- \_\_\_\_\_- \_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PATIENT'S REFERRAL INFORMATION**  **Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_** |
| **Person to Contact In An Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Day Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell/Evening Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (location) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **I acknowledge the above information is correct.**  **Patient Signature (Or Parent, if Minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Sequoia Urology Center**

**FINANCIAL POLICY**

**CASH PATIENTS**

* Full payment at time of service
* We accept CASH, CHECK, and VISA, MASTERCARD, and AMERICAN EXPRESS.

**HMO / PPO HEALTH PLANS**

* “REFERRALS” from your primary care physician and CO-PAYMENTS and / or your percentage are due at the time of your visit or service.

**PRIVATE INSURANCE CARRIERS**

* When we are provided with insurance information, we will submit the visit to your insurance company for you.
* On subsequent visits, we will bill your insurance carrier; although we expect any deductibles and co-payment percentages at the time of your visit. **If your co-payment is not made at the time of your visit a $5 processing fee will be added to your statement.** If your insurance has not paid the full balance within 45 days, then you are responsible and we expect payment from you within 15 days upon the receipt or our statement.

Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. Your insurance claim is filed as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, etc., other than to supply factual information as necessary. **You are ultimately responsible for all charges regardless of any existing medical coverage.**

**MEDICARE, MEDI-CAL, WORKERS COMPENSATION**

* If you are covered by Medicare, Medi-Cal, Workers Compensation or any other government-sponsored program, we require that you have proof of such coverage for billing purposes.

Should your account become past due after insurance payments, you will be responsible for any finance charge or collection charges for this account.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

**CANCELLED APPONTMENTS**

* **This office requires a 24-hour notice if you are unable to keep your scheduled appointment. Office visit cancellations of less than 24-hours will be charged $50.00 and office procedure cancellations of less than 48-hours will be a charge of $75.00.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Responsible Party Signature Dated

**CHRIS THREATT, M.D.**

**MARINA WHITE-NAGY, M.D.**

**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

**I have received the Sequoia Urology Center Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any further Notice of Privacy Practices if amended.**

**I wish to be contacted in the following manner (check all that apply):**

**□ Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Written Communication**

**□ O.K. to leave message with detailed information □ O.K. to mail to my home address**

**□ Leave message with call-back number only □ O.K. to mail to my work/office address**

**□ O.K. to fax to this number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Family members authorized to receive**

**medical information\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ O.K. to leave message with detailed information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ Leave message with call-back number only \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

* ***AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES***

I herby authorize Sequoia Urology Center, Inc. to release any information in the course of my examination and/or treatment to my insurance company(s) for the purpose of billing. I also authorize the release of information to my employer if my examination and/or treatment are work related.

* ***AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN***

I herby authorize the medical and/or surgical benefit payments to be made directly to Sequoia Urology Center. It is understood that benefits are not to exceed the reasonable and customary charge of these services and any monies received from the insurance company over and above indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges not covered by this authorization.

* ***INFORMED CONSENT FOR OFFICE PROCEDURES***

I herby authorize the staff and physicians of Sequoia Urology Center to perform those diagnostic and/or therapeutic office procedures deemed necessary to evaluate and/or treat my current medical illness(es). I make this authorization with the knowledge that the above names company will verbally describe the nature of said procedures in lay terminology, including possible complications, alternatives, and side effects and obtain verbal consent prior to procedures. I retain the right to verbally refuse any procedure, either diagnostic or therapeutic, after being informed of its nature, complications, and side effects.

* ***PATIENT ACKNOWLEDGMENT OF PHYSICIAN DISCLOSURE OF OWNERSHIP % INTEREST***

This is to advise you that the doctors have ownership interest in certain diagnostic equipment and diagnostic treatment centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred. The facilities or centers whereby the physicians have ownership interest may include; but are not limited to:

***I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Patient Name Patient’s Birthdate**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature or authorized representative/ relationship (if applicable) Date**

***Chris Threatt, M.D. Marina White-Nagy, M.D.***

***Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**FEMALE PATIENT HISTORY FORM**

**PATIENT’S NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE**:\_\_\_\_\_

PRIMARY CARE PHYSICIAN (FAMILY DOCTOR)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIEF COMPLAINT** – What is the main reason for your visit to the urologist today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been having this problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HISTORY OF PRESENT ILLNESS

Do you have or have you recently had any of the following listed below? Please circle your response.

* Blood in your urine………………………………………………………………. YES NO
* Weak, dribbling stream or trouble starting your urine (poor force)………… YES NO
* Awaken frequently at night to urinate? If yes, how often?\_\_\_\_\_\_\_............. YES NO
* Burning or pain when you urinate?............................................................. YES NO
* Back pains?................................................................................................ YES NO
* Leakage of urine when coughing, straining, sneezing or exercising?........ YES NO
* Leakage of urine if you don’t get to the bathroom immediately?................ YES NO
* Leakage of urine when getting up from a chair?......................................... YES NO
* Urinating more frequently than usual? If yes, how often?\_\_\_\_\_\_\_............. YES NO
* Discharge from the vagina?........................................................................ YES NO
* Kidney or bladder stones?........................................................................... YES NO
* Urinary tract infections?............................................................................... YES NO
* Bedwetting or daytime wetting of clothes?.................................................. YES NO
* History of a sexually transmitted disease (herpes, gonorrhea, Chlamydia, etc) YES NO
* Pain with sexual intercourse?....................................................................... YES NO
* Skin problems in the genital or groin area?.................................................. YES NO
* Fertility problems?........................................................................................ YES NO
* Have you ever had kidney x-rays (IVP or ultrasound) performed?.............. YES NO
* Are you currently pregnant or are you actively trying to become pregnant? YES NO

**OB/GYN HISTORY**

How many times have you been pregnant? \_\_\_\_

How many vaginal deliveries? \_\_\_\_

How many c-section deliveries? \_\_\_\_

Date of your last period? \_\_\_\_\_\_\_\_\_\_\_

Date of your last Pap smear? \_\_\_\_\_\_\_\_\_\_\_

Have you had a hysterectomy? \_\_\_Yes \_\_\_No

What method do you use to prevent pregnancy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Chris Threatt, M.D. Marina White-Nagy, M.D.***

***Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

PATIENT’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL AND SURGICAL HISTORY**

Serious Medical Illnesses (Check all that apply and provide details below that you feel are important for us to know)

\_\_\_Heart attack? \_\_\_Kidney failure? \_\_\_Diabetes? **→** If yes, do you use insulin?\_\_\_\_\_\_

\_\_\_Heart failure? \_\_\_Chronic lung disease? \_\_\_Cancer? **→** If yes, what type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Heart valve problem? \_\_\_Angina? \_\_\_Asthma? \_\_\_Peptic ulcers?

\_\_\_High cholesterol? \_\_\_Joint replacement? \_\_\_Bleeding disorder? \_\_\_Thyroid problems?

\_\_\_High blood pressure? \_\_\_Neurological/Psychiatric problems? \_\_\_Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVIOUS SURGERIES (PLEASE LIST)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Type** | **Year** | **Type** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**MEDICATIONS (Please write full dosages)**

Please list all prescriptions and over-the-counter medications, including vitamins and herbs that you are taking.

……………………… ……………………… ……………………… ………………………

……………………… ……………………… ……………………… ………………………

……………………… ……………………… ……………………… ………………………

Do you use any nitroglycerin medications (medicine for chest pain?) \_\_\_Yes \_\_\_No

**ALLERGIES TO MEDICATIONS** \_\_\_\_NKDA (No known drug allergies)

………………………… ………………………… Have you had a reaction to iodine x-ray dye? \_\_\_Yes \_\_\_No

………………………… ………………………… If yes, what type of reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

\_\_\_\_\_Married \_\_\_\_\_\_\_Single \_\_\_\_\_\_\_Widowed \_\_\_\_\_\_\_Separated \_\_\_\_\_\_\_Divorced

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many children do you have?\_\_\_\_\_\_

Tobacco: Packs per week \_\_\_\_\_ Quit \_\_\_\_\_ Quit When? \_\_\_\_\_\_ Never \_\_\_\_\_

Alcohol: Beer \_\_\_\_\_\_ /wk Liquor \_\_\_\_\_\_ /wk Wine \_\_\_\_\_\_\_ /wk None \_\_\_\_\_\_

Caffeine: Coffee/day \_\_\_\_\_\_ Tea/day \_\_\_\_\_\_ Chocolate – Yes / No Soft Drinks w/ caffeine/day \_\_\_\_\_

FAMILY HISTORY (Write “F” for father, “M” for mother, “S” for sibling)

\_\_\_\_Prostate cancer \_\_\_\_Heart disease

\_\_\_\_Kidney cancer \_\_\_\_Lung disease

\_\_\_\_Bladder cancer \_\_\_\_High blood pressure

\_\_\_\_Kidney failure \_\_\_\_Neurological problems

\_\_\_\_Kidney stones

\_\_\_\_Other illnesses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Chris Threatt, M.D. Marina White-Nagy, M.D.***

***Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

PATIENT’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you currently have any problems related to the areas outlines below? Please circle all that apply.

* **GENERAL**

Weight loss Loss of appetite Night sweats Fatigue Nausea Fever Chills

\_\_\_\_*Negative Review*

* **HEAD/EYES/EARS/NOSE/THROAT**

Headaches/Migraines Hearing problems Ringing in ears Nasal congestion Eye pain

Dental problems Dry mouth Difficulty swallowing Vision problems Sore throat

\_\_\_\_*Negative Review*

* **RESPIRATORY**

Cough Phlegm Bloody Phlegm Shortness of breath

\_\_\_\_*Negative Review*

* **CARDIOVASCULAR**

Chest pain Irregular heart beat Leg cramps Easy bruising High/Low Blood Pressure

\_\_\_\_*Negative Review*

* **GASTROINTESTINAL**

Pain with swallowing Stomach pain Vomiting Bloody stools Black stools Constipation

Diarrhea

\_\_\_\_*Negative Review*

* **NEUROLOGICAL**

Numbness Tremor Developmental problems Balance problems Poor memory

\_\_\_\_*Negative Review*

* **MUSCULOSKELETAL**

Weakness Difficulty walking Bone or joint pain Loss of muscle mass

\_\_\_\_*Negative Review*

* **ENDOCRINE**

Excessive thirst Temperature intolerance Poor growth

\_\_\_\_*Negative Review*

* **SKIN**

Change in skin or nail texture Itchy skin Hives Dry skin Hair loss

\_\_\_\_*Negative Review*