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Welcome to Northwest United Urology

PATIENT INFORMATION

Last Name:_______________________________ First Name:_____________________________ MI:____

Date of Birth:___________________ Sex: M or F Social Security Number:___________________

Home Address:____

City:____ State & Zip Code:_______________________

Phone Number:________________________________ Email: _________________________________

We will be contacting you at this number regarding tests results and medical information. **We will not be leaving any information on your voicemail if it does not identify your name.**

May we discuss your medical information with someone? Y or N

If yes, Name_________________________________ Relationship_______________ Number__________

Emergency contact Information:

If yes, Name_________________________________ Relationship_______________ Number__________

RESPONSIBLE PARTY FOR INSURANCE COVERAGE or FOR MINOR:

Last Name:_______________________________ First Name:_____________________________ MI:____

Insured's Relationship to Patient___________ Date of Birth:____________ Sex: M or F

1. I have read all of the information on NUU Billing Policy that was provided to me and acknowledge my financial responsibilities.
2. I understand and agree, regardless of my insurance status, I am ultimately responsible for my co-pay, deductible and any non-covered charges.
3. I will be provided with Notice of Privacy Practice upon request.

I certify that I have read all of the information provided to me by NUU, and that to the best of my knowledge that all information that I have provided are correct and true. I will notify this office in case of any changes to my health or any of the information I have provided. I hereby authorize the release of all pertinent medical information to insurance carriers for the purpose of payment.

Signature:____Date:___________

(relationship to patient, if applicable) ________________________________

Last Name:______________________________ First Name:____________________________ MI:____

Who is your referring physician? ____

What is the nature of your visit today?

____

MEDICAL HISTORY:

___ Diabetes Mellitus
___ High Blood Pressure
___ Heart Attack
___ High Cholesterol
___ Congestive Heart Disease
___ Atrial Fibrillation/Flutter
___ Heart Arrhythmias
___ Pacemaker
___ Mitral Valve Prolapse
___ Strokes/ministrokes
___ COPD/ Asthma
___ Sleep Apnea
___ Head/brain bleeding
___ Seizure Disorder
___ Depression
___ Glaucoma
___ Cataract
___ Hearing Loss
___ Blindness
___ Thyroid Disorder
___ Kidney/Renal Failure
___ GERD/Reflux
___ Diverticulitis
___ Crohn's Disease
___ Ulcerative Colitis
___ Hepatitis
___ Osteoporosis
___ Vascular Disease
___ Low Platelet Count
___ Bleeding Disorder
___ Clotting Disorder
___ Anemia

____
____

Cancers (type and date of diagnosis):

____

SURGICAL HISTORY:

____
____
____
____

MEDICATIONS:___________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

ALLERGIES:______________________________ _______________________________________

_______________________________________ _______________________________________

MEDICAL PROBLEMS AFFECTING FAMILY MEMBERS

____

____

SOCIAL HISTORY:

Smoking history: ___ I currently smoke. ___ I quit smoking. ___I have never smoked.
If currently or formerly a smoker, I smoke(d) about ____packs per day, for about ____ years.
Alcohol: ___ Yes ___No
If yes, I drink alcohol ___ daily or heavy ___ moderate or social ___ rare/infrequent.
Any recreational drug use? ___ Yes ___ No
Are you married? ___ Yes ___ No (___ divorced ___ widowed)
Do you have children? ___ Yes (how many ___) or ___ No
Occupation: ____

REVIEW OF SYSTEMS
Do you currently have any of the following symptoms (circle Y or N):

Chills	Y	N	Wheezing	Y	N
Fever	Y	N	Cough	Y	N
Headaches	Y	N	Shortness of breath	Y	N
Excessive thirst	Y	N	High blood pressure	Y	N
Tired/sluggish	Y	N	Chest pain	Y	N
Too hot	Y	N	Varicose veins	Y	N
Too cold	Y	N			
Abdominal Pain	Y	N	Blood clotting problem	Y	N
Heartburn	Y	N	Swollen lymph nodes	Y	N
Nausea	Y	N			
Vomiting	Y	N			
Back Pain	Y	N	Persistent itching	Y	N
Joint Pain	Y	N	Skin rash	Y	N
Neck Pain	Y	N	Boils	Y	N
Urine retention	Y	N	Tremors	Y	N
Painful urination	Y	N	Dizziness	Y	N
Frequent urination	Y	N	Tingling/Numbness	Y	N