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Registration Form

Name: (Last) _____ (First) _____ Driver's Lic #: _____ SSN: ____-____-____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Sex: M ___ F ___ Birth date: ____/____/____
Employer: _____
Business Address: _____ Business Ph. _____
Email: _____ Interested in Patient Portal

Primary Language: _____ Race: _____ Ethnic Group: _____

Emergency Contact:
Name: _____ Phone: _____

PRIMARY INSURANCE

Name of Person Responsible for Account: Last) _____ (First) _____
Relation to Patient _____ Birth date: ____/____/____ SSN: ____-____-____
Address (if different from patient's) _____
City: _____ State: _____ Zip: _____ Phone _____
Person Responsible Employed by _____ Occupation: _____
Business Address: _____ Business Phone _____
Insurance Co. _____ Subscriber# _____ Phone _____

ADDITIONAL INSURANCE? Yes ___ No ___

Name of Person Responsible for Account: (Last) _____ (First) _____
Relation to Patient _____ Birth date: ____/____/____ SSN: ____-____-____
Address (if different from patient's) _____
City: _____ State: _____ Zip: _____ Phone _____
Person Responsible Employed by _____ Occupation: _____
Business Address: _____ Business Phone _____
Insurance Co. _____ Subscriber# _____ Phone _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Washington Urology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date ____/____/____

Name: _____

History of Present Illness

Referring Doctor: _____ Family Doctor: _____

Height: _____ Weight: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

Please list any labs or imaging ordered by your physician for this problem _____

Who was the ordering physician? _____

Have you received your flu shot for this year (Y / N) if no, why not? _____

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/Location: _____ Phone #: _____

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

By what method did you choose our practice:

Referring Physician _____ Friend _____ Yellow Pages _____ Insurance Company _____ Other _____

Name: _____

Past Medical History

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular

Anemia
Angina
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhythmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

Endocrine/Metabolic

Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyroidism
Hypothyroidism
Impaired Glucose Tolerance

General

Allergies

Electrical Injury
Exposure to Chemicals
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholesterolemia
Hyperlipidemia
Infectious Disease
Lipid Disorder
Malaise
Obesity
Paget's disease
PCKD
PCO
Raynaud's Syndrome

GI

Cholecystitis
Cholelithiasis
Chronic Liver Disease
Colitis
Constipation
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
GERD
Hemorrhoids
Hepatic Failure
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis

GU

AIDS
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency
Chronic Renal Failure
Crossed Fused Ectopia
Hematuria
Impotence of Organic Origin

Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Libido Decreased
Nephrolithiasis
Nephrotic Syndrome
Neurogenic Bladder
Orchitis
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure
Recurrent UTI
Renal Cell Cancer
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Transitional Cell CA Bladder
Transitional Cell CA Ureter
Undescended Testicle (Birth)
Urinary Tract Infection
Venereal Disease

GYN/OB

Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids

HEENT

Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Meniere's
Mumps
Sinusitis
Tinnitus
Vertigo

Musculoskeletal

Arthritis
Back Pain
Carpal Tunnel Syndrome
Claudication
Fibromyalgia
Morton's Neuroma

Neuro/Psych

ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory

Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis

Name: _____

Tumors

Brain Cell Carcinoma
Brain Tumor
Breast Cancer
Cervical Cancer

Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma

Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Rectal Cancer
Rectal Cell Cancer

Sarcoidosis
Testicular Cancer
Transitional Cell CA
Bladder
Transitional Cell CA Ureter
Uterine CA

Other: _____

Surgical History

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Cardiovascular

Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General

Brain Surgery
Laminectomy
Lymphatic Node
Dissection
Parathyroidectomy
Pilonidal Cyst Incision
Skin Grafting

GI

Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy
Colon Resection
EGD
EGD/Dilation Esophagus
Fissurectomy
Gastric Surgery
Hemorrhoidectomy
Ileostomy
Laparoscopy
Liver Surgery
Liver Transplant
Lumpectomy of Breast
Lysis Adhesions
Nissen Fundoplication
Splenectomy

Stomach Surgery
Umbilical Hernia
Ventral Hernia Repair

GU

Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelectomy
Ileal conduit
Indigo Laser Surgery
Inguinal Herniorrhaphy
InterStim
Kidney Stone
Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatoclectomy

TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy
VLAP

GYN

Breast Implants
Breast Surgery
Cyst Removal
Delivery Vaginal
Delivery Forceps
Delivery Cesarean
Endometrial Ablation
Hysterectomy
Hysterectomy-Complete
Hysterectomy-Partial
Hysterectomy, Vaginal
Oophorectomy Unilateral
Oophorectomy Bilateral
Rectocele Repair
Tubal Ligation Bilateral

HEENT

Cataract Surgery
Corneal Surgery
Ear Surgery
Eye Surgery
Facial Surgery
Mastoid Surgery
Nasal Surgery
PEG
PE Tubes
Septoplasty
Sinus Surgery
Tonsil Surgery

Thyroid Surgery
TMJ Surgery

Musculoskeletal

Amputation
Arthroscopic Knee-Right
Surgery
Arthroscopic Knee-Left
Surgery
Back Surgery
Carpal Tunnel- Right
Surgery
Carpal Tunnel- Left
Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery- Right
Foot Surgery- Left
Hand Surgery- Right
Hand Surgery- Left
Hip Surgery- Right
Hip Surgery -Left
Knee Surgery- Right
Knee Surgery- Left
Leg Surgery- Right
Leg Surgery- Left
Rotator Cuff Surgery
Shoulder Surgery- Right
Shoulder Surgery- Left

Respiratory

Lung Surgery

Skin

Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

Other: _____

Name: _____

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 ____
of Pregnancies: _____ Currently Pregnant? Yes ____ No ____

Occupation: Please circle one that applies

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time

Other _____ Are you retired? Yes ____ No ____

Hobbies: Please circle 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 per day:

None ____ Yes # ____ Packs/day ____ Cigarettes/day ____ Smokeless Tobacco _____

If you previously stopped, When? _____

Recreational Drugs:

None ____ If yes, please list: _____

Caffeinated beverages:

On average, how many cups (8oz glasses) of the following liquids do you drink daily?

Coffee (reg or decaff) _____ cups/day Soda _____ cups/day Tea _____ cups/day

Juice _____ cups/day Water _____ cups/day Other _____ cup/day

Recent Foreign Travel:

None ____ Americas _____ Worldwide _____

Family History

Please CIRCLE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

Arthritis _____

Leukemia _____

Bedwetting _____

Malignant Melanoma _____

Bladder Cancer _____

Multiple Sclerosis _____

Cancer (site unknown) _____

Laryngeal Cancer _____

Crohn's Disease _____

Pancreatic Cancer _____

Depression _____

Prostate Cancer _____

Diabetes _____

Stroke _____

Gout _____

Thyroid Disease _____

Heart Attack _____

Tuberculosis _____

Hypertension _____

Kidney Cancer _____

Kidney Disease _____

Other: _____

Name: _____

Review of Systems

Constitutional

Appetite Changes
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Swollen Glands
Weight Gain
Weight Loss

Eyes

Blind
Blurred Vision
Double Vision
Glaucoma
Pain
Worsening Eyesight

Allergic/Immunologic

Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

Neurological

Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems

Tremors

Endocrine

Diabetes
Excessive thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold

Gastrointestinal

Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular

Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Orthopnea
Pain/Cramps Hips/Legs w/exercise
Palpitation

Skipped Heart Beats
Swelling

Skin

Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

Musculoskeletal

Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

Ear/Nose/Throat

Ear Infection
Sinus Problem
Sore Throat

Genitourinary

Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying

Painful Ejaculation
Stranguria
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream

Respiratory

Asthma
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of breath
Tuberculosis
Wheezing

Hematologic/Lymphatic

Swollen Glands
Blood clotting problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

Psychologic

Anxiety
Depressed
Generally satisfied with life

Other: _____
