UROLOGY ASSOCIATES
OF CENTRAL CALIFORNIA
MEDICAL GROUP, INC.

7014 N. Whitney, Fresno, CA 93720
Telephone: (559) 321-2800
http://www.urologyassociates.net

PATIENT HISTORY FORM

NAME: _____

DATE: _____

ACCOUNT#: _____

WHAT IS THE REASON FOR YOUR VISIT?

- ☐ **Blood in urine:** ☐ *Visible* ☐ *Invisible*
- ☐ **Elevated PSA**
- ☐ **Incontinence/Female urination symptoms**
- ☐ **Kidney Stones/Bladder stones/ureteral stones**
- ☐ **Abdominal/Flank Pain**
- ☐ **Urologic cancer:** ☐ *Bladder* ☐ *Kidney* ☐ *Prostate*
- ☐ **BPH/Male urination symptoms**
- ☐ **Erectile Dysfunction**
- ☐ **Infertility**
- ☐ **Urinary Tract Infections**
- ☐ **Vasectomy Consultation**
- ☐ **Other, please specify:** _____

How long has this problem been present? _____

Have recent tests been performed for this problem (x-rays, urine cultures, blood tests, etc)? If so, which type and facility? _____

_____

Do you take any blood thinners (such as Aspirin, Plavix, or Coumadin)? ☐ **Yes** ☐ **No**

If yes, which medication? _____

ALLERGIES

Please note any allergies and the reaction that occurs: _____

_____

_____

FAMILY HISTORY

Please indicate if anyone in your immediate family (INDICATE RELATIONSHIP) **has had any of these conditions:**

- ☐ **Diabetes** RELATIONSHIP:
- ☐ **Kidney Stones** RELATIONSHIP:
- ☐ **Kidney disease** *(renal failure)* RELATIONSHIP:
- ☐ **Bladder Cancer** RELATIONSHIP:
- ☐ **Prostate Cancer** RELATIONSHIP:
- ☐ **Other cancer** _____ RELATIONSHIP:
- ☐ **High Blood Pressure** RELATIONSHIP:
- ☐ **Heart Disease** RELATIONSHIP:
- ☐ **Stroke** _____ RELATIONSHIP
- ☐ **Coronary Artery Disease** RELATIONSHIP:
- ☐ **Other** _____ RELATIONSHIP:

PAST MEDICAL HISTORY

Please indicate if you have had any of the following medical conditions in the past:

- ☐ **Diabetes:**
- ☐ **Kidney Stones**
- ☐ **Kidney disease** *(renal failure)*
- ☐ **Bladder Cancer**
- ☐ **Prostate Cancer**
- ☐ **Other cancer** _____
- ☐ **High Blood Pressure**
- ☐ **Heart Disease**
- ☐ **Stroke** _____
- ☐ **Coronary Artery Disease**
- ☐ **Other** _____

SURGERIES

List and date any previous surgeries you have had in the past:

☐ **Cholecystectomy** *(Gall bladder removal)* ☐ **Appendectomy** *(appendix removal)* ☐ **Orthopedic joint replacement**

☐ **Cardiac valvular surgery** ☐ **Cardiac Bypass Surgery** ☐ **Hernia surgery**

☐ **Previous urologic surgery:** _____

☐ **Other surgeries** *(please note below):* _____

_____

_____

_____

_____

SOCIAL HISTORY

Do you currently smoke? ☐ **Yes** ☐ **No**

If yes, how many packs a day? _____ **How many years?** _____

Have you ever quit smoking? ☐ **Yes** ☐ **No**

If yes, when did you quit? _____

How many caffeinated beverages do you drink on a daily basis? _____

Do you drink alcohol? ☐ **Rarely** ☐ **Occasionally** ☐ **Moderately** ☐ **Heavily** ☐ **No**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widow** ☐ **Divorced**

Children: ☐ **Yes** ☐ **No**

If yes, how many? _____ **Number of vaginal deliveries?** _____

Are you sexually active? ☐ **Yes** ☐ **No**

What is your occupation? _____

MEDICATIONS

What medications do you take regularly? Please specify the DOSAGE

_____

_____

_____

_____

_____

PHARMACY INFORMATION

What is your pharmacy of choice? _____

City: _____ **Cross-streets:** _____

Pharmacy phone number: _____

Thank you for taking the time to complete this form so that we may be better able to serve you.

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REVIEW OF SYSTEMS – MALE

Name _____ **Account #** _____ **Date** _____

Physician's Signature _____ **Date** _____

Please indicate whether you are currently experiencing any of the following conditions:

	Yes	No
GENERAL		
PERSISTENT INFECTIONS	☐	☐
CHILLS	☐	☐
FATIGUE	☐	☐
FEVER	☐	☐
WEIGHT GAIN > 10LBS.	☐	☐
WEIGHT LOSS > 10LBS.	☐	☐
HEENT		
BLURRED VISION	☐	☐
HEADACHE	☐	☐
DOUBLE VISION	☐	☐
EYE PAIN	☐	☐
EAR INFECTION	☐	☐
RINGING IN THE EARS	☐	☐
HAYFEVER	☐	☐
SINUS PAIN	☐	☐
SORE THROAT	☐	☐
RESPIRATORY		
COUGH	☐	☐
WHEEZING	☐	☐
DIFFICULTY BREATHING	☐	☐
GASTROINTESTINAL		
ABDOMINAL PAIN	☐	☐
CHANGE IN BOWEL HABITS	☐	☐
CONSTIPATION	☐	☐
DIARRHEA	☐	☐
HEARTBURN	☐	☐
INDIGESTION	☐	☐
NAUSEA	☐	☐
VOMITING	☐	☐
MUSCULOSKELETAL		
BACK PAIN	☐	☐
JOINT PAIN	☐	☐
MUSCLE PAIN	☐	☐
SWELLING OF EXTREMITIES	☐	☐
PSYCHIATRIC		
ANXIETY	☐	☐
MENTAL ILLNESS	☐	☐
DEPRESSION	☐	☐
INSOMNIA	☐	☐
PANIC ATTACKS	☐	☐
ENDOCRINE		
APPETITE CHANGES	☐	☐
COLD INTOLERANCE	☐	☐
EXCESSIVE THIRST	☐	☐
HEAT INTOLERANCE	☐	☐
THYROID PROBLEMS	☐	☐

	Yes	No
SKIN		
CHANGE IN WART/MOLE	☐	☐
RASH	☐	☐
BOILS	☐	☐
NECK		
NECK PAIN	☐	☐
SWOLLEN GLANDS	☐	☐
CARDIOVASCULAR		
CHEST PAIN	☐	☐
FAINTING / BLACKING OUT	☐	☐
IRREGULAR HEART BEAT	☐	☐
ELEVATED BLOOD PRESSURE	☐	☐
PALPITATIONS	☐	☐
RAPID HEART RATE	☐	☐
LEG PAIN AND/OR SWELLING	☐	☐
SHORTNESS OF BREATH	☐	☐
MALE GENITOURINARY		
BLOOD IN URINE	☐	☐
CHANGE IN BLADDER HABITS	☐	☐
CHANGE IN URINARY STREAM	☐	☐
FREQUENCY (FREQUENT URINATION)	☐	☐
IMPOTENCE (SEXUAL DYSFUNCTION)	☐	☐
INCONTINENCE (LOSS OF BLADDER CONTROL)	☐	☐
NOCTURIA (WAKING UP TO URINATE)	☐	☐
PAINFUL URINATION	☐	☐
PENILE LESIONS	☐	☐
TESTICULAR MASS	☐	☐
TESTICULAR PAIN	☐	☐
URETHRAL DISCHARGE	☐	☐
URGENCY	☐	☐
URINARY RETENTION	☐	☐
NEUROLOGICAL		
NUMBNESS	☐	☐
DECREASED MEMORY	☐	☐
DIZZINESS	☐	☐
HEADACHES	☐	☐
SEIZURES	☐	☐
STROKE	☐	☐
TREMOR	☐	☐
UNSTEADINESS	☐	☐
VISUAL CHANGES	☐	☐
HEMATOLOGY		
ABNORMAL BLEEDING	☐	☐
ANEMIA	☐	☐
BLOOD CLOTS	☐	☐
ENLARGED LYMPH NODES	☐	☐
BLOOD CLOTTING PROBLEMS	☐	☐

☐ NARAYANA S. AMBATI, M.D.
☐ KULDIP BEHNIWAL, M.D.
☐ GILBERT DALE, M.D.
☐ PAUL GREWALL, M.D.
☐ CHRISTOPHER JULIAN, M.D.
☐ ROBERT JULIAN, M.D.
☐ YUK-YUEN LEUNG, M.D.
☐ WILLIAM SCHIFF, M.D.
☐ JAMIE DIPIETRO, D.O.
☐ BENJAMIN STEINBERG, D.O.

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PATIENT REGISTRATION (PLEASE PRINT)

PATIENT INFORMATION

Patient: _____ (Last Name) _____ (First Name) _____ (Middle Name)

Home Phone: _____ Daytime Phone: _____ Cell Phone: _____ Pager: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Driver's License #: _____

Patient Employed By: _____ Business Phone #: _____

Referring Physician: _____ (Full Name) Primary Physician: _____ (Full Name)

SPOUSE/RESPONSIBLE PARTY INFORMATION

Responsible Party (if Patient is a minor): _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Driver's License #: _____ Birth Date: _____

Employer: _____ Occupation: _____

Business Address: _____ Day/Business Phone #: _____

Spouse: _____ Social Security #: _____ Driver's License #: _____ Birth Date: _____

Employed By: _____ Occupation: _____

Business Address: _____ Day/Business Phone #: _____

IN CASE OF EMERGENCY (RELATIVE OR FRIEND)	RELATIONSHIP	TELEPHONE

CONSENT

I hereby give consent to release or obtain information to/from physicians and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. This authorization expires one (1) year from the date of signature.

_____ (Patient / Responsible Party Signature) Date ____/____/____ Date ____/____/____ Date ____/____/____

ASSIGNMENT

I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

_____ (Patient / Responsible Party Signature) Date ____/____/____ Date ____/____/____ Date ____/____/____

INSURANCE INFORMATION

Name of Primary Insurer: _____

Address: _____

Policy #: _____ Group #: _____ Subscriber: _____

Name of Secondary Insurer (if any): _____

Address: _____

Policy #: _____ Group #: _____ Subscriber: _____

MEDICARE/MEDI-CAL INFORMATION

☐ **Medicare** ☐ **MediCal Claim ID #:** _____

Medicare Secondary Payer Information:

Are you covered by a medical insurance plan where you work? ☐ Yes ☐ No

Are you covered by a medical insurance plan from your spouse's employer? ☐ Yes ☐ No

Do you have any medical insurance, other than Medicare? ☐ Yes ☐ No

Is that Medicare supplemental insurance? ☐ Yes ☐ No

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HIPAA Patient Signature Log

Privacy Officer
Telephone: (559) 321-2873

To our patients:
All physicians and medical providers are required by law to provide to each patient, a copy of their Notice of Privacy Practices (NPP). This law, also requires us to document that we have given you a copy or have offered to you a copy.

Patient's Name: _____ Account #: _____

Date	Patient Signature	Received Copy	Declined Copy	Declined to Sign	Staff Initial

Note to UACC Staff: If the patient is a minor or if the patient is not able to sign, then a guardian should sign. Staff should 'write in' by the signature, 'guardian'.

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REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION FOR PROTECTED HEALTH INFORMATION (PHI)

Policy:
Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), individuals have the right to request reasonable alternative means of communications from health care providers in order to ensure confidentiality. It is important to ensure that individuals can receive communications regarding their Protected Health Information (PHI) in a means and location that the individual feels is safe from unauthorized use or disclosure. Urology Associates of Central California (UACC) will accommodate reasonable requests by individuals to receive communications of PHI from the UACC covered health care providers by alternative means or at alternative locations.

Procedure:

1. Patients must request alternative means of confidential communications in writing, using this form Request for Alternative Means of Communication. Reasonable requests include using alternative telephone numbers, alternative addresses, and allowing leaving messages of PHI on answering machines.
2. UACC covered health care providers will not require any explanation from the individual of the reason for the request as a condition of providing alternative communications on a confidential basis.
3. Knowledge of a violation or potential violation of this policy must be reported directly to the UACC HIPAA Privacy Officer, at 559-321-2873.

Patient Name:_____ Account #:_____

DOB:_____ Primary Provider:_____

Preferred Phone Number:_____ Contact Name:_____

I authorize UACC to leave messages on my answering machine/voicemail for the following:
☐ Appointment Information ☐ Treatment Information ☐ Medical Results

I authorize UACC to call the following location (i.e., nursing home) to discuss appointment information, treatment information, and medical results:

Type of Location: _____ Name of Location: _____

Contact Name: _____ Contact Phone Number: _____

_____ _____
Patient/Guardian Signature Date