



Welcome to Urology Health Specialists, LLC.

In order to serve you better, please carefully read and complete the attached forms.

Please arrive 15 minutes prior to your appointment time so we may process all necessary paperwork. Please bring the following:

- All of the attached patient information and history forms – completed.
- Your insurance card
- Co-payment amounts are due at the time of service.
- If your insurance requires one, a REFERRAL from your primary physician
- The name and phone number of your primary care physician.
- List of all medications/allergies.
- Copies of all recent lab test results, x-rays and medical records.
- Money for parking at our Abington, Chestnut Hill, Lankenau and Nazareth locations.

If you need to cancel your appointment, please notify us 24 hours in advance. A fee will be assessed for all no-shows or cancellations without 24 hours notice.

Directions to all Urology Health Specialists locations can be found on our website at [www.uhsurology.com](http://www.uhsurology.com).

If you have any questions prior to your appointment, please call our office.

Thank you.

UROLOGY HEALTH SPECIALISTS

[www.uhsurology.com](http://www.uhsurology.com)

**UROLOGY HEALTH SPECIALISTS, LLC**  
**PATIENT REGISTRATION FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

E-mail address: \_\_\_\_\_ Social Security # \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_ M \_\_\_ F

Spouse/Partner name: \_\_\_\_\_

If minor, name of Parent/Guardian: \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Partnered \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Employment Status: Currently not employed \_\_\_\_\_ Employed \_\_\_\_\_ Retired \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship of Emergency Contact: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Local Pharmacy: \_\_\_\_\_ Phone # \_\_\_\_\_

Mail Order Pharmacy Plan Name: \_\_\_\_\_

Explain any special requirements for pharmacy plan – Quantity/Time interval

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PLEASE SHOW INSURANCE CARD AT EACH VISIT.

**INSURANCE  
PRIMARY**

Primary Subscriber Name: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

**INSURANCE  
SECONDARY**

Subscriber Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

I hereby authorize Urology Health Specialists, LL to furnish my medical or other information to insurance carriers, their intermediaries, my attorney, or another physician's office. I understand that sensitive material from my medical history could be included.

I hereby assign to Urology Health Specialists, LLC all payments for medical services rendered to myself or my dependents. I understand I have financial responsibility for any amount whether or not paid by insurance.

A copy of this authorization is as valid as the original. This assignment will remain in effect until revoked by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**UROLOGY HEALTH SPECIALISTS, LLC**

**PATIENT INFORMATION AND HISTORY**

**HISTORY OF PRESENT ILLNESS**

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**REASON FOR VISIT:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**When did you first notice the problem?**  2 days ago  2 weeks ago  Other \_\_\_\_\_

**Are your symptoms getting worse?** \_\_\_\_\_

**Is the problem**  constant or variable  dull then sharp  very sharp then leaves  always

**Does the problem interfere with your normal activities?**  Yes  No (If yes, explain) \_\_\_\_\_

\_\_\_\_\_

**Is there anything else occurring at the same time?**  Yes  No (If yes, explain) \_\_\_\_\_

\_\_\_\_\_

Nausea  Rash  Headache  Fever  Other \_\_\_\_\_

**Have you had this problem before?**  Yes  No  I don't know

**Have you had prior urological evaluation or surgery?**  Yes  No  I don't know

**What is your level of pain right now (with 1 being the least bothersome and 10 being severe)?** \_\_\_\_\_

**Any recent tests related to this problem? (Blood work, urine test, radiology examination)** \_\_\_\_\_

\_\_\_\_\_

**PAST SURGICAL HISTORY (FOR ANY MEDICAL PROBLEM) List any past surgeries and dates.**

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY-ILLNESSES OR HOSPITALIZATION (List with date first diagnosed)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DO YOU HAVE ANY FOOD OR DRUG ALLERGIES?**  Yes  No  
 (Please refer to page 5 to list any allergies and allergic reactions)

**DO YOU SMOKE?**  Yes  No **If Yes, how much?/years?** \_\_\_\_\_  
 I quit **Date stopped** \_\_\_\_\_

**DO YOU DRINK ALCOHOL?**  Yes  No

**If yes, how much?**  Occasionally  3-4X per week  Every day  Other \_\_\_\_\_

**ARE YOU ON A SPECIAL DIET?**  Yes  No

**If yes, describe** \_\_\_\_\_  Weight loss  Diabetic  Low sodium  Low carbohydrates

**DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL OR OTHER PROCEDURES?**  Yes  No

**If yes, what do you take?** \_\_\_\_\_ **If so, why?** \_\_\_\_\_

**FAMILY HISTORY**

<b><u>ILLNESS</u></b>	<b><u>FATHER</u></b>	<b><u>MOTHER</u></b>	<b><u>BROTHER(S)</u></b>	<b><u>SISTER(S)</u></b>	<b><u>GRANDFATHER</u></b>	<b><u>GRANDMOTHER</u></b>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	_____	_____	_____	_____	_____
Family Members that are deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other family history information: \_\_\_\_\_

## REVIEW OF SYSTEMS

**Do you now or have you had any problems related to the following systems? Check Yes or No.**

Please explain any Yes answers in space provided.

### Constitutional Symptoms

Fever  Yes  No  
Chills  Yes  No  
Headache  Yes  No  
Other \_\_\_\_\_

### Integumentary

Skin rash  Yes  No  
Boils  Yes  No  
Persistent itch  Yes  No  
Other \_\_\_\_\_

### Eyes

Blurred vision  Yes  No  
Double vision  Yes  No  
Pain  Yes  No  
Other \_\_\_\_\_

### Musculoskeletal

Joint pain  Yes  No  
Neck pain  Yes  No  
Back pain  Yes  No  
Other \_\_\_\_\_

### Allergic/Immunologic

Hay Fever  Yes  No  
Drug allergies  Yes  No  
Other \_\_\_\_\_

### Ear/Nose/Throat/Mouth

Ear infection  Yes  No  
Sore throat  Yes  No  
Sinus problems  Yes  No  
Other \_\_\_\_\_

### Neurological

Tremors  Yes  No  
Dizzy spells  Yes  No  
Numbness/tingling  Yes  No  
Other \_\_\_\_\_

### Genitourinary

Urine retention  Yes  No  
Painful urination  Yes  No  
Urinary frequency  Yes  No  
Other \_\_\_\_\_

### Endocrine

Excessive thirst  Yes  No  
Too hot/cold  Yes  No  
Tired/sluggish  Yes  No  
Other \_\_\_\_\_

### Respiratory

Wheezing  Yes  No  
Frequent cough  Yes  No  
Shortness of breath  Yes  No  
Other \_\_\_\_\_

### Gastrointestinal

Abdominal pain  Yes  No  
Nausea/vomiting  Yes  No  
Indigestion/heartburn  Yes  No  
Other \_\_\_\_\_

### Hematologic/Lymphatic

Swollen glands  Yes  No  
Blood clotting problem  Yes  No  
Other \_\_\_\_\_

### Cardiovascular

Chest pain  Yes  No  
Varicose veins  Yes  No  
High blood pressure  Yes  No  
Other \_\_\_\_\_

### Psychologic

Are you generally satisfied with your life?

Yes  No

Do you feel severely depressed?  Yes  No

Have you considered suicide?  Yes  No

Other \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

**WOMEN ONLY – GYNECOLOGIC/OBSTETRIC HISTORY**

Age at onset of periods \_\_\_\_\_ Frequency \_\_\_\_\_ Length \_\_\_\_\_

Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_

Prolonged abnormal bleeding  No  Yes (Describe) \_\_\_\_\_

Leakage of urine  No  Yes (Describe) \_\_\_\_\_

Pelvic pain  No  Yes (Describe) \_\_\_\_\_

Abnormal discharge  No  Yes (Describe) \_\_\_\_\_

History of abnormal Pap test  No  Yes (Describe) \_\_\_\_\_

