NORTHWEST IOWA UROLOGISTS

Patient Name _____ Date _____

Street Address_____City_____State_____ Zip_____

SSN:_____ Telephone _____Cell phone_____

Gender_____ Birthdate _____Age_____ Marital Status M____S_____W_____D_____

Email address (for accessing your medical records)_____

Spouse Name _____Spouse birthdate_____ Spouse SSN: _____

Employer for patient or parent if child_____ Work phone_____

Spouse Employer_____ Work Phone_____

Emergency Contact _____Telephone_____

Family Physician _____Pharmacy_____

Allergies to Medications/Dyes _____

Prescription Medications (may copy list) _____

_____

Over-The-Counter Medications _____

_____

Previous Surgeries _____

_____

Previous Hospitalizations _____

Other Medical Conditions _____

Please list past/present medical conditions for
Your mother: _____
Your father: _____
Siblings: _____

Do you use tobacco? _____Yes _____No If yes, how much/what kind _____

Do you drink alcoholic beverages? _____ Yes _____ No If yes, how many? _____

Do you drink caffeinated beverages? _____ Yes _____ No What kind/how many? _____

Height _____Weight_____ **Please proceed to backside of this page**……

Review of Systems (please circle yes or no)

Constitutional		**Cardiovascular**		**Respiratory**	
Fever	Y N	Chest pain	Y N	Cough	Y N
Chills	Y N	High blood pressure	Y N	Shortness of breath	Y N
Headache	Y N	Swelling	Y N	Wheezing	Y N
Eyes		**Integumentary**		**Hematological**	
Blurred vision	Y N	Skin rash	Y N	Anemia	Y N
Eye pain	Y N	Persistent itching	Y N	Swollen glands	Y N
Double vision	Y N	Boils	Y N	Bleeding problems	Y N
Neurological		**Musculoskeletal**		**Psychological**	
Tremors	Y N	Back pain	Y N	Anxiety	Y N
Dizzy spells	Y N	Joint pain	Y N	Depression	Y N
Endocrine		**ENT**			
Excessive thirst	Y N	Ear Infections	Y N		
Too hot/cold	Y N	Sore throat	Y N		
Tired/sluggish	Y N	Sinus problems	Y N		
Gastrointestinal		**Urological**			
Abdominal pain	Y N	Blood in Urine	Y N		
Nausea/vomiting	Y N	Difficult urination	Y N		
Indigestion	Y N	Incontinence	Y N		
		Kidney Stones	Y N		
		Urinary infections	Y N		

INSURANCE INFORMATION - PLEASE PRESENT ALL CARDS FOR PHOTOCOPYING

Insurance Company Name _____Subscriber date of birth _____

Policy Number _____

I do hereby voluntarily consent to permit any associated physician or provider of Northwest Iowa Urologists, PC, to perform diagnostic procedures and such medical treatment or procedures as necessary or advisable in their judgment for my medical care.

I authorize Northwest Iowa Urologists, PC to release medical information, per HIPPA regulations, about me to my insurance company or to other doctor offices. I authorize direct payment of medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Northwest Iowa Urologists, PC. I acknowledge that I have received a copy of the Notice of Privacy Practices from Northwest Iowa Urologists, PC.

Signature of Patient (or guardian, if minor) _____ Date _____