(Please Fill Out Completely)

Date: ________________________

Home Phone#: __________________________
Cell Phone#: ____________________________
Work Phone#: ___________________________
E-mail: ____

Date of Birth: _______________ Age: ________ Marital Status: M S D W Sex: Male Female

Patient Last name: ________________________ First: _________________________ Middle: ___________________

Address:____ City: ____________________ State: _______ ZIP: __________

Patient Employer: ____ Occupation: ________________________________

Ok to release medical information? ☐ YES ☐ NO To the following person(s):

1. _________________________ 2. ____________________________ 3. _______________________

Parent Name: ____________________________ Parent Name: _________________________________

Applies only to parents of minor children or children insured under the parents' insurance

Referring Doctor: ____ Phone: ________________________________

Primacy Care Doctor: ______________________________________ Phone: ________________________________

Pharmacy Name/Location: ________________________________ Phone: ________________________________

Emergency Contact: ____ Phone: ________________________________

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Indian/Pakistani/SriLankan ☐ Chamorran ☐ Chinese

☐ Fiji Islander ☐ Filipino ☐ GuamanianNOS ☐ Hawaiian ☐ Japanese ☐ Kampuchean/Cambodian ☐ Korean ☐ Laotian

☐ MelanesianNOS ☐ MicronesianNOS ☐ Samoan ☐ Tahitian ☐ Thai Tongan ☐ Vietnamese

☐ Other: ____

I understand that I am financially responsible for all the charges incurred including office expenses, laboratory fees, pathology fees, and outpatient/inpatient procedure charges. This is to include all charges not covered by my medical insurance. I also understand that if my insurance requires a referral, I am responsible for obtaining the referral and keeping up with the expiration dates.

____________________________________ Patient's signature or Guardian's signature

____________________________ Date

MEDICAL HISTORY FORM

(please complete form)

Today's date: ______________________ Height: ______________ Weight: ___________

Name: ______________________________________ Birthdate: _______________________
(first name) (last name)

UROLOGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- Any pain or burning when voiding/urinating?
- Any urgency or need to run to the bathroom?
- Any urinary frequency or need to void many times during the night?
- Any sense of incomplete emptying of your bladder?
- Any leakage of urine?
- Any blood in urine?
- Any pain? If yes, where is your pain located? ____

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

CURRENT MEDICATIONS: LIST ALL MEDICATIONS – INCLUDING OVER THE COUNTER MEDS.

DRUG NAME	STRENGTH	DIRECTIONS/HOW YOU TAKE IT:

(ATTACH LIST IF NECESSARY)

DRUG ALLERGIES: ☐ **YES** ☐ **NO**

____

____

NAME: ______________________________________ **DOB:** ________________________________

REVIEW OF SYSTEMS: *CIRCLE ALL PROBLEMS YOU ARE CURRENTLY EXPERIENCING:*

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

ENDOCRINE

Diabetes
Excessive Thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too hot/cold

GI

Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
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
Palpitation
Skipped Heart Beats
Swelling
Pain/Cramp Hips-
Legs w/Exercise

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

GENITOURRINARY/UROLOGY

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 Bedwetting
Not Emptying
Painful Ejaculation
Stranguria
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge
Weak Stream

RESPIRATORY

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

HEMATOLOGICAL/ LYMPHATIC

Swollen Glands
Blood Clotting Problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickie Cell

PSYCHOLOGIC

Anxiety
Depressed
Generally satisfied with life

PAST MEDICAL HISTORY: **IF YES, please CIRCLE if you have or have had any of the following conditions:**

CARDIOVASCULAR

Anemia
Angina
Aortic Aneurysm
Arrythmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication
Congestive Heart failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Disease
Heart Murmur
Hemophilia
Hypertension
Hypertension, severe
Mitral Valve Prolapse
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

OB/GYN

Breast Cancer
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids

HEENT

Blindness
Cataracts
Deafness
Ear Infections
Glaucoma
Mumps
Sinusitis
Tinnitus
Vertigo

ENDOCRINE

Diabetes Mellitus,
Non-insulin dependent
Diabetes Mellitus,
insulin dependent
Goiter
Gout
Hyperthyroidism
Hypothyroidism

GENERAL

Allergies
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholesterolemia
Hyperlipidemia
Lipid Disorder Obesity
PCKD
PCO
Raynaud's Syndrome

MUSCOLOSKETAL

Arthritis
Back Pain
Carpal Tunnel Syndrome
Fibromyalgia
Mortons Neuroma

NEUROLOGICAL/PSYCHOLOGICAL

ADD
Alcoholism
Alzheimer's Disease
Anxiety
Chronic Fatigue Syndrom
Depression
Eating Disorder
Epilepsy
Herniated Disc
Migraine
Multiple Sclerosis
Parkinson's
Seizures
Spinal Cord Injury
Stroke

GI

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

RESPIRATORY

Asthma
Bronchitis
COPD
Emphysema
Pneumonia
Pulmonary Embolism
Tuberculosis

GU- Urological

AIDS
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Failure
Hematuria
Impotence of Organic Origin
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Infection
Kidney Stones
Sleep Apnea

GU- Urological

Libido Decreased
Nephrolithiasis
Neurogenic Bladder
Orchitis
Penile Discharge
Polycystic Disease
Prostate Cancer
Recurrent UTI
Renal Cell Cancer
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Transit Cell CA Bldr
Transit Cell CA Ureter
Undescended Testicle
(Birth)
Urinary Tract Infection
Venereal Disease

TUMORS

Brain Cell Carcinoma
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Gastric Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Sarcoidosis
Testicular Cancer
Transitional Cell CA Bldr
Transitional Cell CA Ureter
Uterine CA

SURGICAL HISTORY: IF YES, please list all surgeries including dates (MONTH/YEAR)

NAME OF PROCEDURE	DATE

FAMILY HISTORY: IF YES, please check box ☐ and indicate which family member has/had any of the following: (Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

☐ Adrenal Disease ___________________________
☐ Bedwetting ________________________________
☐ Bladder Cancer ____________________________
☐ Crohn's Disease ___________________________
☐ Diabetes __________________________________
☐ Gout ______________________________________
☐ Heart Attack ______________________________
☐ Heart Disease _____________________________
☐ Hypertension ______________________________
☐ Kidney Cancer __________________________________
☐ Kidney Disease _________________________________
☐ Kidney Stones __________________________________
☐ Multiple Sclerosis _____________________________
☐ Prostate Cancer ________________________________
☐ Stroke ____
☐ Thyroid Disease ________________________________
☐ Tuberculosis ___________________________________

SOCIAL HISTORY:

MARITAL STATUS:	DEPENDENTS - Please indicate number of each, If you have:
☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**	_____ **Sons** _____ **Daughters** ____ **Stephchildren** ______ **Adopted** ______ **Foster** _____**Grandparents**

1. **ALCOHOL CONSUMPTION:** None Yes Occasional/Social # of drinks per day _____________
2. **TOBACCO:** ☐ None ☐ Yes # ______packs/day __________cigarettes/day ☐ Smokeless Tobacco

** If you previously stopped, when?

3. **RECREATIONAL DRUGS:** ☐ None ☐ Yes, Please list:
4. **CAFFEINATED BEVERAGES:** ☐ None ☐ Low ☐ Moderate ☐ Excessive

Consent for Purpose of Treatment, Payment, and Health Care Operations

I consent to the use or disclosure of my protected health information by Texas Urology Specialists for diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations. I understand that diagnosis or treatment of me by all doctors of Texas Urology Specialists may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" encompasses health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the practice's health care operations. Texas Urology Specialists is not required to agree to the restrictions that I may request, however, if Texas Urology Specialists agrees to a requested restriction, that restriction is binding on both the practice and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Texas Urology Specialists has acted in reliance on this consent.

I understand I have a right to review Texas Urology Specialists' **Notice of Privacy Practices** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or the performance of health care operations of Texas Urology Specialists. It also describes my rights and Texas Urology Specialists' duties with respect to my protected health information.

Texas Urology Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I understand that I am financially responsible for all the charges incurred including office expenses, laboratory fees, pathology fees, and outpatient/inpatient procedure charges. This is to include all charges not covered by my medical insurance. I also understand that if my insurance requires a referral, I am responsible for obtaining the referral and keeping up with the expiration dates.

I authorize Texas Urology Specialists to call my home or work to remind me of an appointment or to reschedule an appointment. I also authorize Texas Urology Specialists to leave scheduling information on my answering machine, or voicemail system.

_______________________________________ _____________________
Signature of Patient or Personal Representative Date

_______________________________________ ____
Printed Name of Patient or Personal Representative Description of Personal Representative's Authority

CANCELLATION & NO-SHOW POLICY

We strive to render excellent medical care to you and the rest of our patients, so we understand that situations arise in which you must cancel your appointment. To provide all our patients with the highest level of care and access we request that all patients that need to cancel their appointment provide more than 24-hours' notice. This will enable us to better utilize available appointments for our patients.

Appointments cancelled with less than 24-hours or if the patient no-shows without notification may be subject to a cancellation fee. The cancellation fees are provided below based on type of appointment.

Office Visits	$ 50.00
In-Office procedures	$ 100.00
Hospital procedures	$ 250.00

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next scheduled appointment.

Please contact our office should you have any questions regarding the cancellation and no-show fees and we will be glad to assist.

____ _______________________

Patient Name (please print) **Date of Birth**

____ _______________________

Patient Signature or Patient Representative **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Urology Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights regarding your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Urology Specialists.

Name (Please Print): ____

Signature: ____

Name of Personal Representative (if appropriate): ___________________________________

Signature of Personal Representative (if appropriate): ________________________________

Date: _________________________

_ _

Texas Urology Specialists Use Only

Date acknowledgement received: __________________________________

- OR -

Reason acknowledgement was not obtained:

____

Steven W. Sukin, M.D **Miguel Mercado, M.D** **Penner Schraudenbach, M.D** **Stephen Schatz, M.D**

Tomball
506 Graham Dr. #150 Tomball, TX 77375
Phone: 281-351-5174 Fax: 281-351-5172
The Woodlands
17189 I-45S, MOB II, #305 The Woodlands, TX 77385
Phone: 281-351-5174 Fax: 281-351-5172
Willowbrook
13215 Dotson Rd. #170 Houston, TX 77070
Phone: 281-517-0808 Fax: 281-351-5172

Authorization Request for Medical Records

I hereby authorize use or disclosure of protected health information about me as described below

I ________________________________ authorize **Steven W. Sukin M.D, Miguel Mercado M.D, Penner Schraudenbach M.D, Steven Schatz M.D** to request any and all medical information from the following persons and or facilities.

Physician/Facility ____________________________________

Address: ____

Telephone: ____

Fax: ____

For the purpose of ☐ Continued Care ☐ Attorney/Legal ☐ Personal Use ☐ Insurance ☐ Other

Please release the following:

☐ Problem List ☐ X-Ray/Imaging Reports
☐ Progress Notes ☐ Laboratory Results
☐ History/Physical Exam ☐ EKG Reports
☐ Medication List ☐ Genetic Testing Information
☐ Immunization Record ☐ Other (Specify) ____
☐ List of all allergies

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying Texas Urology Specialists. However, I understand that any action already taken in advance of this authorization cannot be reversed and revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether I sign the authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

______________________________ ________________________ ______________________
Signature of Individual Date of Signature Date of Birth

Signature of Guardian (if applicable)	Date of Signature	Description of Guardian

Texas Urology Specialists – Tomball

506 Graham Dr. Suite 150
Tomball, TX 77375

Phone: 281-351-5174
Fax: 281-351-5172