UROLOGY CENTER OF SOUTH FLORIDA, P.A.

William K. Skinner, M.D.
Joseph N. Biase, M.D.
Stuart M. Popowitz, M.D.

PATIENT INFORMATION

Date: _____ Account #: _____ ☐ New Patient ☐ Follow Up

Patient: _____ (Last) _____ (First) _____ (MI) _____ (Preferred) _____ (Title)

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient Date of Birth: _____ Patient SSN: _____

Address: _____ Home: _____

Cell: _____

_____ _____ _____ Other: _____

City State ZIP

Out of State Address: _____ Fax: _____

Primary Doctor: _____

_____ _____ _____

City State ZIP

Email: _____ Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ _____ _____

Name Relationship Phone

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Work: _____

Address: _____ Direct: _____

Other: _____

_____ _____ _____

City State ZIP

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Secondary Insurance Carrier: _____

Policy Number: _____ Policy Number: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber Employer: _____ Subscriber Employer: _____

Subscriber SSN: _____ DOB: _____ Subscriber SSN: _____ DOB: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical or medial benefits. I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in course of my treatment necessary to process insurance claims.

_____ _____

Patient Signature Date:

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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ _____ _____ Date: _____
City State ZIP

PAST MEDICAL HISTORY

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY) ☐ NONE

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BARRETT'S ESOPHAGUS
- ☐ BLEEDING DISORDER
- ☐ BLOOD TRANSFUSION
- ☐ CANCER
- ☐ CHRONIC ANXIETY
- ☐ CHRONIC SINUSITIS
- ☐ CIRRHOSIS
- ☐ COLON CANCER
- ☐ COLON POLYPS
- ☐ CONGESTIVE HEART FAILURE
- ☐ CONSTIPATION
- ☐ COPD
- ☐ CORONARY ARTERY DISEASE
- ☐ CROHN'S DISEASE
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIVERTICULITIS
- ☐ FATTY LIVER
- ☐ GALLBLADDER DISEASE
- ☐ GASTRITIS
- ☐ GERD (REFLUX)
- ☐ GI BLEEDING
- ☐ HEART ATTACK
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIATAL HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROLS
- ☐ HIV OR AIDS
- ☐ IRREGULAR HEART BEAT
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY DISEASE/ FAILURE
- ☐ KIDNEY STONES
- ☐ LIVER DISEASE
- ☐ NEUROLOGIC DISORDERS
- ☐ OSTEOPOROSIS
- ☐ OVARIAN CYST
- ☐ PANCREATITIS
- ☐ PARKINSON'S DISEASE
- ☐ PEPTIC ULCER
- ☐ OTHER - PLEASE LIST: _____
- ☐ PHLEBITIS
- ☐ PNEUMONIA
- ☐ PROSTATE ENLARGEMENT
- ☐ PSORIASIS
- ☐ RHEUMATIC FEVER
- ☐ SCIATICA
- ☐ SEIZURES
- ☐ SLEEP APNEA
- ☐ STROKE
- ☐ TB (TUBERCULOSIS)
- ☐ THYROID DISORDERS
- ☐ ULCERATIVE COLITIS
- ☐ VASCULAR HEART DISEASE

SURGERIES/ PROCEDURES

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ APPENDECTOMY
- ☐ BARIUM ENEMA
- ☐ BREAST SURGERY
- ☐ CAPSULE ENDOSCOPY
- ☐ CHOLECYSTECTOMY
- ☐ COLON SURGERY
- ☐ COLONOSCOPY
- ☐ COLOSTOMY
- ☐ C-SECTION
- ☐ EGD
- ☐ ERCP
- ☐ GALLBLADDER SURGERY
- ☐ HEART BYPASS
- ☐ HEART VALVE REPLACEMENT
- ☐ HEMORRHOID SURGERY
- ☐ HIATAL HERNIA REPAIR
- ☐ HYSTERECTOMY
- ☐ JOINT REPLACEMENT
- ☐ KIDNEY SURGERY
- ☐ LIVER BIOPSY
- ☐ OBESITY SURGERY
- ☐ OVARIAN SURGERY
- ☐ PACEMAKER PLACEMENT
- ☐ PROSTATE (TURP)
- ☐ RADIATION THERAPY
- ☐ SIGMOLDOSCOPY
- ☐ OTHER - PLEASE LIST: _____
- ☐ SMALL BOWEL RESECTION
- ☐ STOMACH SURGERY
- ☐ THYROID SURGERY
- ☐ TONSILLECTOMY
- ☐ TUBAL LIGATION
- ☐ ULCER SURGERY
- ☐ UPPER GI SERIES X-RAY
- ☐ UTERINE SURGERY

SOCIAL HISTORY

☐ NONE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED
OCCUPATION: _____ ☐ UNEMPLOYED ☐ RETIRED
SMOKING HISTORY: ☐ NEVER ☐ YES _____ PACK A DAY FOR _____ YEARS; QUIT _____ (HOW LONG)
OTHER TOBACCO USE: ☐ NO ☐ YES; DETAILS: _____
ALCOHOL USE: ☐ NO ☐ YES; AMOUNT PER DAY: _____
DRUG USE: ☐ NO ☐ YES; SPECIFY DRUGS & AMOUNTS: _____
EXERCISE HABITS: ☐ NO ☐ YES; HOW MUCH & HOW OFTEN: _____
RECENT TRAVEL OUTSIDE US: ☐ NO ☐ YES; WHERE: _____
CAFFEINE USE: ☐ NO ☐ YES; HOW MUCH & HOW OFTEN: _____
VOLUNTARY TATTOO: ☐ NO ☐ YES; WHEN: _____

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REVIEW OF SYSTEMS

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

☐ NONE

GENERAL
- ☐ CHILLS
- ☐ FEVER
- ☐ LOSS OF APPETITE
- ☐ NIGHT SWEATS
- ☐ WEIGHT GAIN
  AMOUNT? _____
- ☐ WEIGHT LOSS
  AMOUNT? _____
- ☐ FEELING TIRED OR POORLY

EYES
- ☐ WORSENING VISION
- ☐ BLURRED VISION
- ☐ VISION DISTORTION
- ☐ EYE PAIN

OTOLARYRIGEAL SYMPTOMS
- ☐ EARACHE
- ☐ NASAL DISCHARGE
- ☐ MOUTH SORES
- ☐ BLEEDING GUMS
- ☐ HOARSENESS
- ☐ THROAT PAIN
- ☐ FACIAL PAIN
- ☐ SINUS PAIN

CARDIOVASCULAR
- ☐ CHEST PAIN/DISCOMFORT
- ☐ FAST HEART RATE
- ☐ SWELLING OF LEGS
- ☐ VARICOSE VEINS
- ☐ OTHER - PLEASE LIST: _____
- ☐ OTHER - PLEASE LIST: _____

RESPIRATORY
- ☐ CHRONIC COUGH
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH
- ☐ OTHER - PLEASE LIST: _____
- ☐ OTHER - PLEASE LIST: _____

GASTROINTESTINAL
- ☐ ABDOMINAL PAIN
- ☐ BLACK STOOLS
- ☐ RED BLOOD IN BOWEL MOVEMENT
- ☐ CHANGE IN BOWEL MOVEMENT FREQUENCY
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ BLOATING/GAS
- ☐ HEARTBURN
- ☐ HEMORRHOIDS
- ☐ GALLBLADDER DISEASE
- ☐ NAUSEA
- ☐ DECREASE IN APPETITE
- ☐ RECTAL BLEEDING
- ☐ RECTAL PAIN
- ☐ INCONTINENCE OF STOOL

MUSCULOSKELETAL
- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS
- ☐ SWOLLEN JOINTS
- ☐ LOW BACK PAIN
- ☐ MUSCLE PAIN

SKIN SYMPTOMS
- ☐ PRURITIS (ITCHING)
- ☐ SKIN LESIONS
- ☐ RASHES

NEUROLOGIC
- ☐ NUMBNESS OR TINGLING
- ☐ DIZZINESS/LIGHTHEADEDNESS
- ☐ VERTIGO
- ☐ HEADACHES
- ☐ WEAKNESS IN ARMS OR LEGS
- ☐ BLURRED VISION
- ☐ MEMORY LAPSES OR LOSS
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ PANIC ATTACKS
- ☐ LOSS OF SLEEP

ENDOCRINE
- ☐ HEAT OR COLD INTOLERANCE
- ☐ EXCESSIVE THIRST
- ☐ EXCESSIVE URINATION
- ☐ HOT FLASHES

HEMATOLOGIC/ LYMPHATIC
- ☐ EASY BRUISING TENDENCY
- ☐ SWOLLEN GLANDS
- ☐ NOSEBLEEDS

URINARY
- ☐ PAIN OF DIFFICULTY WITH URINATION
- ☐ FREQUENT URINATION
- ☐ BLOOD IN URINE
- ☐ INCONTINENCE OF URINE
- ☐ KIDNEY STONES

GENITOREPRODUCTIVE FEMALE
- ☐ VAGINAL DISCHARGE
- ☐ HEAVY PERIODS
  DATE OF LAST PERIOD _____

GENITOREPRODUCTIVE MALE
- ☐ DISCHARGE FROM PENIS
- ☐ TESTICULAR PAIN
- ☐ TESTICULAR LUMP
- ☐ ERECTILE DYSFUNCTION

Today's Date: _____

Patient Name: _____ Date of Birth: _____

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FAMILY HISTORY

	FATHER	MOTHER	SIBLING	OTHER
☐ COLON POLYPS	☐	☐	☐	
☐ COLON CANCER	☐	☐	☐	
☐ GASTRIC ULCER DISEASE	☐	☐	☐	
☐ LIVER DISEASE	☐	☐	☐	
☐ PANCREAS DISEASE	☐	☐	☐	
☐ CROHN'S DISEASE	☐	☐	☐	
☐ ULCERATIVE COLITIS	☐	☐	☐	
☐ STOMACH CANCER	☐	☐	☐	
☐ DIABETES MELLITUS	☐	☐	☐	
☐ HEART ATTACK	☐	☐	☐	
☐ BREAST CANCER	☐	☐	☐	
☐ OTHER CANCER	☐	☐	☐	
☐ OTHER: _____	☐	☐	☐	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ASPIRIN ☐ CODEINE ☐ LACTOSE INTOLERANCE ☐ SLEEPING PILLS
☐ ANESTHETIC - LOCAL ☐ DAIRY ☐ METAL SENSITIVITY ☐ SULFA DRUGS
☐ BARBITURATES ☐ LATEX ☐ NITROUS OXIDE SEDATION ☐ PENICILLIN/OTHER ANTIBIOTICS
☐ OTHER - PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS ☐ ANTIHISTAMINES/ALLERGY ☐ DAILY ASPIRIN ☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS ☐ CANCER/CHEMO MEDICATIONS ☐ CORTISONE/STEROIDS ☐ HEART MEDICATION/DIGITALIS
☐ INSULIN ☐ NITROGLYCERIN ☐ ORAL CONTRACEPTIVES ☐ OSTEOPOROSIS MEDICATIONS
☐ OTHER DIABETIC MEDICATIONS ☐ RECREATIONAL DRUGS ☐ THYROID MEDICATIONS ☐ TRANQUILIZERS
☐ OTHER (PLEASE LIST)

DRUG NAME	DOSAGE	REASON PRESCRIBED

ETHNICITY / RACE / LANGUAGE

ETHNICITY
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ ETHNICITY NOT KNOWN BY PATIENT
☐ DECLINED TO SPECIFY ETHNICITY

RACE
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ ASIAN
☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ WHITE

PREFERRED LANGUAGE
☐ ENGLISH
☐ SPANISH
☐ OTHER _____
☐ ADDITIONAL LANGUAGE
_____

Today's Date: _____

Patient Name: _____ Date of Birth: _____

UROLOGY CENTER
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Boynton Beach, FL 33437
Phone **(561) 737-9191** • Fax **(561) 737-2413**

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RECONCILIATION OF MEDICATIONS

Patient Name _____ Date of Birth _____

Patient Signature _____ Today's Date _____

Allergies: _____ ☐ No known allergies

HOME MEDICATION LIST

1. Include all prescription, over the counter, vitamin and herbal products
2. Draw a line through any item that bas been stopped, with the date in the last column
3. Write in NEW or CHANGED items below the last entry listed

DATE	MEDICATION NAME (Please print)	DOSE (how many milligrams)	ROUTE (orally, etc.)	HOW OFTEN IS THE PRODUCT TAKEN?	DATE LAST TAKEN "UNK" if Unknown	DATE STOPPED OR CHANGED
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		
				_____(# of times daily) ☐ PRN for		

Date	Reviewer Signature/Emp#	Action Taken	Copy Sent/Given to:	
		☐ No change in therapy ☐ Changes indicated	☐ Patient ☐ Next provider of care	☐ Patient refused to provide information
		☐ No change in therapy ☐ Changes indicated	☐ Patient ☐ Next provider of care	☐ Patient refused to provide information
		☐ No change in therapy ☐ Changes indicated	☐ Patient ☐ Next provider of care	☐ Patient refused to provide information
		☐ No change in therapy ☐ Changes indicated	☐ Patient ☐ Next provider of care	☐ Patient refused to provide information

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INCONTINENCE QUESTIONAIRE

Patient Name: _____

Date of Birth: _____ Date of Service: _____

1. During the last 3 months, have you leaked urine (even a small amount)?

_____ Yes

_____ No (If you answered NO, please stop here).

1. During the last 3 months, have you leaked urine (even a small amount)?

_____ A) When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?

_____ B) When you had the urge or feeling that you needed to empty your bladder, but could not get to the toilet fast enough?

_____ C) Without physical activity and without a sense of urgency?

D) How frequently did you leak mine?

Times per day: _____

At what times: Daytime: _____ Nighttime: _____

E) How bothersome was this?

Somewhat: _____ Very Bothersome _____

_____ _____

Signature of Physician/Staff Date

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ELECTRONIC PRESCRIPTION INFORMATION

This form must be completed in order for us to fill ANY prescription. Please be sure you provide accurate information to avoid a delay in your prescription processing time.

Patient Name: _____

Date of Birth: _____

Local Pharmacy Name: _____

Local Pharmacy Phone: _____

Local Pharmacy Address: _____

_____ _____ _____

City State Zip Code

Mail in Pharmacy Information

Pharmacy Name: _____

Pharmacy Number: _____

I understand that is my responsibility to provide accurate pharmacy information and to keep the office updated on any pharmacy changes.

Patient Signature: _____

Today's Date: _____

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DESIGNATION OF HEALTH CARE SURROGATE

Print Patient Name: _____ Patient Date of Birth _____

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Surrogate Name: _____

Relationship to Patient: _____

Address _____

Phone Number: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

2nd Surrogate Name: _____

Relationship to Patient: _____

Address: _____

Phone Number: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Patient Signature _____ Date _____

Witness _____ Witness 2 _____

(At least one witness MUST NOT be a husband or wife or a blood relative of the patient.)