Central Arizona Urologists, Ltd.

CONFIDENTIAL

Please PRINT and complete ALL information

Name: ______________________________ Date: __________

First Middle Last

Date of Birth: ____-____-____ Social Security #: ____-____-____

Home Phone #: (______)__________ Work Phone #: (______)__________

Cell Phone #: (______)__________ E-Mail Address: __________

State ID/Driver's License #: __________ Issuing State: __________

Marital Status: ______ Name of Spouse: __________ Number of Children: ______

Mailing Address: ______________________________

Street Number Apt. # City State Zip

Patient's Employer: __________

Referring Doctor/PCP: __________ Phone #: (______)__________

First Last

Nearest Relative: __________ Relationship: ______ Phone #: (______)__________

Not Living at Same Address

Insurance Information:

Primary: __________ ID#: __________ Group #: __________

Insured Name: __________ Insured's Social Security #: ____-____-____

Insured's Employer: __________

Secondary: __________ ID#: __________ Group #: __________

Insured Name: __________ Insured's Social Security #: ____-____-____

Insured's Employer: __________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to James R. Fishman, M.D., M. Michael Hayyeri, M.D., and Aziz O. Mahoubi, M.D. of the surgical and/or medical benefits, if any, otherwise payable to me for services rendered to me or my dependent. I also authorize my doctor to release information regarding my treatment. I understand that I am financially responsible for all charges.

__________________________ __________

Patient Signature **Date**

HIPPA Notification:

I acknowledge that Central Arizona Urologists are in compliance with HIPPA laws regarding the Notice of Privacy Practices. This notice describes how Central Arizona Urologists may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I understand these policies are posted within the office and a copy of these policies is available upon my request.

According to these policies, I understand that unless written permission is given patient information can only be released to the patients themselves. In compliance with these policies, I hereby entitle authorization for my personal information to be discussed with the following people:

Name	*Relationship*	*Phone #*

☐ OK to leave voicemails at Home Phone #

☐ OK to leave voicemails at Work Phone #

__________________________ __________ ______ ______

Signature of Patient **Date** Staff Initials Date

MEDICAL AND SURGICAL HISTORY

I. Why are you consulting a urologist? ____________________

II. Past Medical and Surgical History:

A. Surgeries

	Surgeries	Hospital	Surgeon	Year
1.				
2.				
3.				
4.				
5.				
6.				

B. Medical Illnesses	Yes	No	Hospitalized Yes	Hospitalized No	If yes, why
1. Heart Disease	❑	❑	❑	❑	
2. High Blood Pressure	❑	❑	❑	❑	
3. Lung Disease (COPD)	❑	❑	❑	❑	
4. Diabetes	❑	❑	❑	❑	
5. Cancer	❑	❑	❑	❑	
6. Kidney Disease	❑	❑	❑	❑	
7. Gastrointestinal Disease (Ulcers, Diverticulitis, etc.)	❑	❑	❑	❑	
8. Bleeding Problems	❑	❑	❑	❑	
9. Sexually Transmitted Disease	❑	❑	❑	❑	
10. Other: ____________	❑	❑	❑	❑	

III. Medications (Including aspirin and vitamin/herbal)

	Name	Dosage	Frequency		Name	Dosage	Frequency
1.				5.			
2.				6.			
3.				7.			
4.				8.			

IV. Allergies (to any medications or tapes) ❑ No ❑ Yes If Yes, to what

	Name	Reaction		Name	Reaction
1.			4.		
2.			5.		
3.			6.		

V. Family History

	Living	Deceased	Illnesses	Age & Cause of Death
Father	❑	❑		
Mother	❑	❑		
Sisters	#___ ❑	#___ ❑		
Brothers	#___ ❑	#___ ❑		

VI. Family History of the Following:

	Yes	No		Yes	No		Yes	No
1. Heart Disease	❑	❑	4. Cancer(s)	❑	❑	7. Bleeding Problems	❑	❑
2. Kidney Disease	❑	❑	5. Diabetes	❑	❑	8. Other: ____________	❑	❑
3. Prostate Disease	❑	❑	6. Gastrointestinal Problems	❑	❑			

VII. Social Habits

	Yes	No	Amount/ How many years?/ When did you quit?
1. Do you smoke?	❑	❑	
2. Do you drink alcohol?	❑	❑	
3. Any drugs (illicit)?	❑	❑	
4. Any caffeine use?	❑	❑	
Coffee	❑	❑	
Tea	❑	❑	
Sodas	❑	❑	
5. Any blood transfusions?	❑	❑	

VIII. Do you have any of these symptoms?

	Yes	No
1. Constit.		
Fever	❑	❑
Wt. Loss	❑	❑
Loss of Appetite	❑	❑
2. Eyes		
Vision Blurring	❑	❑
Double Vision	❑	❑
3. ENT.		
Trouble Swallowing	❑	❑
Ringing in Ears	❑	❑
4. Cardiovascular		
Chest Pain	❑	❑
Shortness of Breath	❑	❑
Palpitation	❑	❑
Swelling of Legs	❑	❑
5. Resp.		
Cough	❑	❑
Cough up blood	❑	❑
Breathing difficulty	❑	❑
6. GI.		
Nausea	❑	❑
Vomiting	❑	❑
Belly Pain	❑	❑
Diarrhea	❑	❑
Blood Stool	❑	❑
7. Musculo-skeletal		
Arthritis	❑	❑
Muscle weakness	❑	❑
8. Integumentary		
Skin rashes	❑	❑
9. Neurological		
Strokes	❑	❑
10. Psychiatric		
Memory Loss	❑	❑
Change in Personality	❑	❑
11. Endocrine		
Intolerance to Heat	❑	❑
Intolerance to Cold	❑	❑
Constant Thirst	❑	❑
12. Hematologic/Lymphatic		
Lymph Node Swelling	❑	❑
Bruise Easily	❑	❑