Arizona State Urological Institute
The Center for Comprehensive Urological Care

Patient Name:_____ **Date of Birth:** ____/____/____

Please answer the following to the best of your ability. If you are unable to fill out these forms or need assistance, ask the front desk for additional help.

I authorize the following people to access my medical records and information:

Name (First and Last)	Date of Birth (MM/DD/YYYY)	Relationship
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____

Arizona State Urological Institute (ASUI) commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. Please select a security question below to verify with the individuals who are authorized to access and discuss your medical records with our office.

☐ Security PIN: _____

☐ Security Question: _____
Answer: _____

☐ Security Phrase: _____

Ok to leave a detail message: ☐ No ☐ Yes _____
List Number ok to leave message on:

Do you have any children? [ ] Yes [ ] No If yes, how many: _____
Do you currently smoke? [ ] Yes [ ] No If yes, how often: _____
Are you a former smoker? [ ] Yes [ ] No If yes, how many years: _____
Do you chew tobacco? [ ] Yes [ ] No

Do you drink alcohol? [ ] No [ ] socially [ ] 1-2 per day [ ] 3-4 per day [ ] Over 4 per day

Have you ever used illegal drugs? [ ] Yes [ ] No

If yes, list what kind(s): _____

Are you currently sexually active? [ ] Yes [ ] No

Have you ever had a sexually transmitted disease (STD)? [ ] Yes [ ] No

If yes, please list type:_____ Date:_____
Type:_____ Date:_____
Type:_____ Date: _____

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PATIENT CONTACT LIST

Please provide current information that our office can use to contact individuals on your behalf in case of disconnected number, difficulty with reaching you, or an emergency.

Emergency Contact: Indicate any person who should be notified in case you experience a medical emergency while at our office.

EMERGENCY CONTACT

Name:_____ Date of Birth:_____/_____/_____

Relationship:_____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

Non-Emergent Contact: Indicate persons who we may contact if we are having difficulty reaching you. Note: Unless you authorize the following individuals to access your protected health information (PHI), they may not receive test results or office visit information on your behalf.

NON-EMERGENT CONTACT #1

Name:_____ Date of Birth:_____/_____/_____

Relationship:_____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

NON-EMERGENT CONTACT #2

Name:_____ Date of Birth:_____/_____/_____

Relationship:_____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

NON-EMERGENT CONTACT #3

Name:_____ Date of Birth:_____/_____/_____

Relationship:_____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

_____ _____/_____/_____

Print Patient Name: Date

_____

Signature of patient or patient representative

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arizona State Urological Institute (ASUI) is commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. 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 this 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 Arizona State Urological Institute.

_____ _____/_____/_____

Signature of Patient or Personal Representative Date

_____

Printed name of Patient or Personal Representative

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What medical conditions have you been diagnosed with (Example: Diabetes, high blood pressure, etc.)

☐ No Known past medical conditions

List conditions below:

What medical conditions are in your family history (Example: Diabetes, high blood pressure, etc.)

☐ No Past Medical History Known

List family member condition:	Relative

Are you allergic to any medications or medical products?

☐ No Known Drug Allergies

List allergy	Reaction

Past Surgical Procedures/ Surgeries. List name, where and date please.

☐ No prior surgical procedures or surgeries

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Please list the medication that you take currently. (If you have a list, please turn list in with your packet, or front desk can make a copy for your chart.) If taking No medications, write N/A or NONE.

Medication Name:	**Strength:**	**Frequency:**	**Duration:**

Preferred Pharmacy Information: (List Local and Mail order if applicable)

Local Pharmacy Name:_____ Phone Number: (_____)_____-_____

Address or Cross Streets: _____

Probable Zip Code: _____

Preferred Mail Order Pharmacy:

Pharmacy Name:_____Phone Number: (_____)_____-_____

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Please review the following checklist, and only check the medical conditions that apply to you. (If a condition applies to someone in your family, but you do not have it, do not check the box for that condition.)

Constitutional
- ☐ Recent appetite change
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fatigue
- ☐ Fever
- ☐ Chills

Skin
- ☐ Hives
- ☐ Itching
- ☐ Rash

Allergy/Immunologic
- ☐ Cancer (Type:_____)
- ☐ Seasonal Allergies

ENMT
- ☐ Hearing change
- ☐ Nosebleeds
- ☐ Tinnitus (Ringing in ears)

Eyes/Head
- ☐ Dizziness
- ☐ Headaches
- ☐ Changes to vision

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

Cardiovascular
- ☐ Edema (Swelling)
- ☐ Chest pain/discomfort
- ☐ Syncope (Fainting)

Gastrointestinal
- ☐ Bloody stools
- ☐ Recent bowel changes
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Constipation

Genitourinary
- ☐ Weak urinary stream
- ☐ Painful urination
- ☐ FEMALES: Vaginal discharge
- ☐ MALES: Penile discharge

Endocrine
- ☐ Diabetes (Type 1 or 2:_____)

Musculoskeletal
- ☐ Bursitis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Muscle/joint stiffness
- ☐ Back pain/injuries
- ☐ Arthritis

Neurological
- ☐ Epilepsy
- ☐ Palsy
- ☐ Speech changes
- ☐ Stroke
- ☐ Tingling

Hematologic/Lymphatic
- ☐ Anemia (Low iron)
- ☐ Easy bruising