MIU Adult Information

Patient Name: _____ Chart # / Office: _____

Home / Cell Phone: _____ Referring Physician: _____

**Pharmacy Name & Phone:** _____ Date: _____

## PLEASE ANSWER *ALL* QUESTIONS:

**What is your reason for your visit today?** _____

_____

## ALLERGIES

Are you Allergic to any medication? ☐ No ☐ Yes **(If yes please list & describe the reaction below.)**

| MEDICATION ALLERGY | REACTION |
|---|---|
| | |
| | |
| | |
| | |

**Are you allergic to: Latex** ☐ No ☐ Yes **Iodine** ☐ No ☐ Yes **Dye or contrast material** ☐ No ☐ Yes **Other** _____

## MEDICATION

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐ NO ☐ YES (If yes please list all current medications prescribed by other physicians including over the counter supplements and herbal medications. ) **Please list below ↓↓**

| MEDICATIONS | DOSE (example one 20mg tablet once daily | DISCONTINUE DATE | PRESCRIBING DOCTOR |
|---|---|---|---|
| | | | |
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| | | | |

Do you take Aspirin? ☐ No ☐ Yes Do you take a Blood Thinner? ☐ No ☐ Yes If yes what Blood Thinner? _____

***Do you require medications or antibiotics before procedures?*** ☐ ***Yes*** ☐ ***No***

## SURGICAL HISTORY

**SURGICAL HISTORY - Please list & note dates of your surgeries:** _____

_____

_____

**Do you have drug eluding cardiac stents? If yes when were they inserted?** _____

**UROLOGIC SURGERY - Please list & note dates of your urology surgeries:** _____

_____

_____

## MEDICAL HISTORY

**MEDICAL PROBLEM - Please list your Major Medical Problems & Dates of Hospitalizations:** _____.

_____

_____

**UROLOGIC MEDICAL PROBLEM - Please list your Major Medical Problems & Dates of Hospitalizations:** _____

_____

_____

**FAMILY medical history**; have any family members had:

**Cancer** ☐ No ☐ Yes, **if yes where?** ☐Prostate ☐ Kidney ☐ Bladder ☐ Breast ☐ Other: _____
Family member: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Brother ☐ Sister ☐ Aunt ☐ Uncle
☐ Runs in the Family ☐ No Family History

**Heart Problems** ☐ No ☐ Yes, **if yes who?**
Family member: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Brother ☐ Sister ☐ Aunt ☐ Uncle
☐ Runs in the Family ☐ No Family History

**Kidney Disease** ☐ No ☐ Yes, **if yes who?**
Family member: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Brother ☐ Sister ☐ Aunt ☐ Uncle
☐ Runs in the Family ☐ No Family History

**Diabetes** ☐ No ☐ Yes, **if yes who?**
Family member: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Brother ☐ Sister ☐ Aunt ☐ Uncle
☐ Runs in the Family ☐ No Family History

**PLEASE COMPLETE REVERSE SIDE ⇉**

## SOCIAL HISTORY

**Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

**Smoking Status** ☐ **Current** Every Day **Smoker** ☐ Current Some Day (Occasional) Smoker ☐ Packs smoked per day _____
When did you start smoking? _____ Approximately ____ ☐ Days ☐ Weeks ☐ Months ☐ Years Ago
☐ **Former Smoker**
When did you quit smoking? _____ Approximately ____ ☐ Days ☐ Weeks ☐ Months ☐ Years Ago
☐ Packs smoked per day _____ How long did you smoke ____ ☐ Days ☐ Weeks ☐ Months ☐ Years
☐ **Never smoked** ☐ Smoker current status unknown ☐ Unknown if ever smoked

**Do You Drink Alcohol?** ☐ **Never Drank**
☐ **Yes,** Drinks per Day___ Week ___ Month ___ Year ____ Type of alcohol consumed ☐ Beer ☐Wine ☐Liquor
Drinking Habits: ☐ Social ☐ Light ☐ Moderate ☐ Excessive
☐ **Not Anymore** When did you quit? _____ Approximately ____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago
How long did you drink? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years
How much did you drink? _____ Drink/s per ☐ Day ☐ Week ☐ Month ☐ Year

**How many caffeinated drinks do you have each day?** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

**Have you had a blood transfusion?** ☐ Yes ☐ No

**What language do you speak?** ☐ English ☐ Spanish ☐ French ☐ German ☐ Portuguese ☐ Russian ☐ Chinese ☐ Japanese ☐ Italian ☐ Arabic ☐ Other _____

**What race are you?** ☐ White ☐ Black African American ☐ American Indian / Alaska Native ☐Eskimo ☐ Native Hawaiian / Pacific Islander ☐ Hispanic ☐ Asian ☐ Unknown _____

**What ethnicity are you?** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

## GENERAL REVIEW OF SYSTEMS: Are you currently having any of the following?

**Genitourinary**
Incontinence ☐ Y ☐ N
Voiding difficulties ☐ Y ☐ N
Painful urination ☐ Y ☐ N
Incomplete emptying ☐ Y ☐ N
Urinary frequency ☐ Y ☐ N
Blood in Urine ☐ Y ☐ N
Stones ☐ Y ☐ N
Currently sexually active ☐ Y ☐ N
Sexually Transmitted Disease ☐ Y ☐ N
Other _____

**Male**
Trouble with erections ☐ Y ☐ N
Trouble with Ejaculation ☐ Y ☐ N
Libido Problems ☐ Y ☐ N
Low Testosterone ☐ Y ☐ N
Infertility ☐ Y ☐ N
Other _____

**Female**
Do you still have a menstrual period ☐ Y ☐ N
Number of pregnancies _____
Number of Vaginal Births _____
Most recent pelvic / pap exam _____
Other _____

**Cardiovascular**
Chest Pain ☐ Y ☐ N
High blood Pressure ☐ Y ☐ N
Elevated Cholesterol ☐ Y ☐ N
Irregular Heartbeat ☐ Y ☐ N
Other _____

**Psychologic** *next column →*
Depression ☐ Y ☐ N
Bi-Polar disorder ☐ Y ☐ N
Manic depressive ☐ Y ☐ N
Anxiety ☐ Y ☐ N
Other _____

**Endocrine**
Hot Flashes ☐ Y ☐ N
Excessive Thirst ☐ Y ☐ N
Too Hot / Too Cold ☐ Y ☐ N
Thyroid Problems ☐ Y ☐ N
Other _____

**Gastrointestinal**
Constipation ☐ Y ☐ N
Nausea / Vomiting ☐ Y ☐ N
Hernia ☐ Y ☐ N
Abdominal Pain ☐ Y ☐ N
Other _____

**Respiratory**
Shortness of Breath ☐ Y ☐ N
Wheezing ☐ Y ☐ N
Frequent Cough ☐ Y ☐ N
Pneumonia ☐ Y ☐ N
Other _____

**Constitutional Symptoms**
Fever / Chills ☐ Y ☐ N
Weight Loss ☐ Y ☐ N
Fatigue ☐ Y ☐ N
Anorexia ☐ Y ☐ N
Other _____

**Neurological**
Headache ☐ Y ☐ N
Tremors ☐ Y ☐ N
Dizziness ☐ Y ☐ N
Seizures ☐ Y ☐ N
Other _____

**Musculoskeletal**
Flank Pain /CVA Tenderness ☐ Y ☐ N
Back Pain ☐ Y ☐ N
Neck Pain ☐ Y ☐ N
Joint Pain ☐ Y ☐ N
Other _____

**Hematologic / Lymphatic**
Bleeding Tendencies ☐ Y ☐ N
Swollen Glands ☐ Y ☐ N
Lymphoma / Leukemia ☐ Y ☐ N
Other _____

**Integumentary**
Skin Rash ☐ Y ☐ N
Boils ☐ Y ☐ N
Skin Infection ☐ Y ☐ N
Other _____

**Ears, Nose & Throat**
Hearing Problems ☐ Y ☐ N
Sore Throat ☐ Y ☐ N
Swallowing Issues ☐ Y ☐ N
Other _____

**Allergy / Immunological**
Seasonal Allergies ☐ Y ☐ N
Other _____

**Eyes**
Blurred Vision ☐ Y ☐ N
Double Vision ☐ Y ☐ N
Other _____

**PATIENT SIGNATURE:** _____ **Date:** _____

**MEDICATION REVIEW - FOR OFFICE USE ONLY**

| DATE REVIEWED | MA INITIALS | DATE REVIEWED | MA INITIALS | DATE REVIEWED | MA INITIALS | DATE REVIEWED | MA INITIALS | DATE REVIEWED | MA INITIALS |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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MICHIGAN INSTITUTE OF **UROLOGY**

## NOTICE OF PRIVACY PRACTICES

## PATIENT ACKNOWLEDGEMENT

Please sign this form below to acknowledge that you have received a copy of the Privacy Statement from Michigan Institute of Urology.

Patient Signature _____ Patient Name (printed) _____

Date _____

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## DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by completing the revocation form. You may obtain this form from the front desk personnel.

*Please note:* This form does not grant permission to release medical records to these designated representatives. Requests for medical records must be made separately.

| Name | Relationship | Phone Number |
|---|---|---|
| Name | Relationship | Phone Number |
| Name | Relationship | Phone Number |

Patient Signature _____ Date _____