Urologic Physicians and Surgeons, P.A.
a division of Urology Group of Florida

Neill Borland, MD
Murray Goldberg, MD
Stephanie Cindric, ARNP
Joseph Tojar, PA-C

Demographic Information

Name: _____ DOB: _____ Sex: **M** **F**

Primary Address: _____
(Street and Apt #) (City) (State) (Zip)

Secondary Address: _____
(Street and Apt #) (City) (State) (Zip)

Home Number: (____) _____ ( ) None Cell Number: (____) _____

Email Address: _____ (used only for patient portal)

Patient Guardian (if applicable): _____ DOB: _____

If you are the legal guardian for this patient, please provide the supporting documentation to the Front Office.

Emergency Contact: _____ Phone Number: (____) _____

Relationship to Patient: _____

Primary Insurance: _____ ID#: _____

Cardholder Name and DOB (if different from the patient): _____

Secondary Insurance: _____ ID#: _____

Cardholder Name and DOB (if different from the patient): _____

PCP: _____ Referred by: _____

How did you hear about us? _____

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring healthcare provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assessment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductible, co-insurance and copays. I understand that I am financially responsible for any charges not covered by my insurance, and if I fail to give updated, current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged $35.00. If we determine your account should be placed with an outside collection agency, or an attorney, you will be assessed with an additional 50% of the balance due.

Patient/Guardian Signature: _____ Date: _____

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History and Intake Form

Patient Name: _____ Date of Birth: _____

Primary and/or Referring Physician: _____

Pharmacy Location and Contact: _____

Main Reason for your visit: _____

Social History:

Do you smoke? YES NO If "YES", how many packs per day? _____

Have you previously smoked? YES NO How many packs per day did you smoke? _____
When did you stop? _____ In years, how long did you smoke? _____

Do you drink alcoholic beverages? YES NO Occasionally
If "YES", how many on a daily basis? _____

Past Medical History: (Please check "YES" for all that apply)

	YES	NO		YES	NO		YES	NO
Anxiety	☐	☐	Coronary Artery Disease	☐	☐	High Cholesterol	☐	☐
Arthritis	☐	☐	Depression	☐	☐	Hyperthyroidism	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Hypothyroidism	☐	☐
Atrial Fibrillation	☐	☐	End Stage Renal Disease	☐	☐	Leukemia	☐	☐
Bone Marrow Transplant	☐	☐	GERD	☐	☐	Lung Cancer	☐	☐
BPH	☐	☐	Hearing Loss	☐	☐	Lymphoma	☐	☐
Breast Cancer	☐	☐	Heart Attack	☐	☐	Radiation Treatment	☐	☐
Colon Cancer	☐	☐	Hepatitis	☐	☐	Seizures	☐	☐
COPD	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
			HIV/AIDS	☐	☐			

Other: _____

OB/GYN History:

When was your last menstrual period? _____

Have you ever been pregnant? YES NO
If "YES", please answer the following questions.

- How many times have you been pregnant (Para)? _____
- How many children have you given birth to (Gravida)? _____
- Any Cesarean Sections? How many? _____

Surgical History: **(Please list all surgeries you have had and when they occurred)** ☐ No Surgeries

☐ Bladder Surgery: _____

☐ Kidney Surgery: _____

☐ Joint Replacement: _____

☐ Cardiovascular: _____

☐ Reproductive: _____

Please list all other surgeries, if not listed above:

_____

_____

_____

_____

Urologic Disease History: **(Please check "YES" for all that apply)**

	YES	NO		YES	NO		YES	NO
Blood in Urine	☐	☐	Stones (Urolithiasis)	☐	☐	STD/STI	☐	☐
Cancer (Bladder)	☐	☐	Neurogenic Bladder	☐	☐	Urethral Stricture	☐	☐
Cancer (Kidney)	☐	☐	Painful Urination (Dysuria)	☐	☐	Urinary Incontinence	☐	☐
Genitourinary Trauma	☐	☐	Polycystic Kidney Disease	☐	☐	Urinary Retention	☐	☐
Hydronephrosis	☐	☐	Renal Insufficiency	☐	☐	Urinary Tract Infection	☐	☐
			Renal Tubular Acidosis	☐	☐	Vesicoureteral Reflux	☐	☐

Other: _____

Family History: **(Please check "YES" for all that apply and indicate Family Member)**

	YES	NO	
Kidney Cancer	☐	☐	Who: _____
Bladder Cancer	☐	☐	Who: _____
Prostate Cancer	☐	☐	Who: _____
Genital Cancer	☐	☐	Who: _____
Kidney Stones	☐	☐	Who: _____
Kidney Disorders	☐	☐	Who: _____
Bleeding Disorders	☐	☐	Who: _____
Heart Disease	☐	☐	Who: _____

Allergies: **(Please list any allergies and type of reaction)** ☐ No Known Drug Allergies

Allergies	Reaction

Review of Systems (Please check all POSITIVE complaints.) ☐ No Positive Complaints

Constitutional: ☐Chills ☐Fever ☐Weight loss

Eyes: ☐Blurred Vision ☐Eye Pain ☐Worsening Eyes

Allergies: ☐Drug ☐Food ☐Seasonal

Neurological: ☐Dizzy ☐Headache ☐Seizures

Endocrine: ☐Thirst ☐Tired ☐Hot/Cold

GI: ☐Heartburn ☐Diarrhea ☐Constipation

Kidney Disease: ☐Renal Failure ☐Transplant

Cardio: ☐Chest Pains ☐Swollen ankles ☐High Blood Pressure

Skin: ☐Rash ☐Lesions ☐Psoriasis

Musculoskeletal: ☐Arthritis ☐Cramps ☐Gout

ENT: ☐Sore Throat ☐Ear Infections ☐Sinus Problems

Respiratory: ☐Asthma ☐Shortness of Breath ☐Cough

Hematologic: ☐Anemia ☐Easy Bleeding ☐Swollen Glands

Psychologic: ☐Anxiety ☐Depression ☐Suicidal Thoughts

Other Conditions: _____

Please select the most appropriate answer to the following questions.

	Never	Rarely	Sometimes	Half the Time	Often	Always
How often do you have difficulty in postponing urination?	☐	☐	☐	☐	☐	☐
How often do you leak urine during activities like coughing, sneezing, lifting or exercise?	☐	☐	☐	☐	☐	☐
How often do you have a strong need to empty your bladder before you start to leak urine?	☐	☐	☐	☐	☐	☐
How often do you lose (leak) urine while you are sleeping?	☐	☐	☐	☐	☐	☐
How often do you lose (leak) urine when you do not want to?	☐	☐	☐	☐	☐	☐
How many times do you urinate during the day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5+
How many times do you get up at night to urinate?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5+

Have you received treatment for urinary incontinence (leakage) in the past? ☐ YES ☐ NO

Do you wear a form of protection for your leakage? ☐ YES ☐ NO If "YES", how many pads per day? _____

Do you see blood in your urine? ☐ YES ☐ NO

How would you feel if you had to live with your urinary condition the way it is now, no better and no worse, for the rest of your life?

☐ Delighted ☐Pleased ☐Mostly Satisfied ☐Mixed ☐Unhappy ☐Terrible

Please turn this page over to continue.

Please list any medications and complete the following table to the best of your abilities:
(If you need more space, we will gladly provide you with another sheet of paper.)

□ No Medications

Medication Name	Dose	Frequency	Route (i.e., Oral, topical, injection, etc.)

I hereby attest that the information provided on this form is accurate and truthful.

_____ _____

Patient/Guardian Signature Date

_____

Patient/Guardian Printed Name

UROLOGIC PHYSICIANS AND SURGEONS, P.A.
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(561)833-5594

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Jupiter, Fl 33458
(561)748-9104

Dear Patient:

As part of our EHR (Electronic Health Record) Program, we are testing the ability to provide our patients with a clinical summary of your last visit with your Physician.

If you wish to receive a clinical summary, please contact the office where you were seen. The office will print a copy and you can pick it up from that office within 3 business days following your appointment.

Please review the clinical summary. We believe the summary will provide you with relevant information from your visit. If you notice any major discrepancies, you may send a written request for changes to the office in which you were seen. If you prefer, you may bring the changes to your next visit.

Confirmation of receipt of notification:

_____
Patient Name (PRINT)

_____
Patient Name (SIGNATURE)

Date_____

Thank you,
Urologic Physicians and Surgeons, P.A.