

**UROLOGIC CONSULTANTS, P.C.**  
**PRELIMINARY PATIENT QUESTIONNAIRE FOR ADULTS**

PATIENT'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

**REFERRING PHYSICIAN**

First and Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

Have any other family members been seen at Urologic Consultants?  Yes  No

If yes, please list name and relationship \_\_\_\_\_

**PAST MEDICAL HISTORY**

Are you on a special diet?  Yes  No If yes, what one? \_\_\_\_\_

Are you allergic to any medications?  Yes  No List: \_\_\_\_\_

Are you taking any medications?  Yes  No List: \_\_\_\_\_

What illnesses do you have? (i.e.- diabetes, high blood pressure, heart disease, emphysema, etc.) \_\_\_\_\_

What hospitalizations have you had? \_\_\_\_\_

What operations have you had? \_\_\_\_\_

**FAMILY HISTORY/SOCIAL HISTORY**

Comments

Family history of cancer  Yes  No \_\_\_\_\_

Family history of cancer of prostate  Yes  No \_\_\_\_\_

Family history of kidney disease  Yes  No \_\_\_\_\_

Family history of kidney stones  Yes  No \_\_\_\_\_

Family history of bleeding problems  Yes  No \_\_\_\_\_

Is your Mother living?  Yes  No \_\_\_\_\_

Is your Father living?  Yes  No \_\_\_\_\_

Are you married?  Yes  No If yes, spouses name? \_\_\_\_\_

Are you employed?  Yes  No If yes, type of work? \_\_\_\_\_

Do you smoke?  Yes  No \_\_\_\_\_

Do you use alcohol?  Yes  No \_\_\_\_\_

How many years of education completed? \_\_\_\_\_

## REVIEW OF SYSTEMS

PATIENT'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_

Do you now or have you ever had any problems related to the following?

### Constitutional Symptoms

Fever  Yes  No  
Chills  Yes  No  
Headache  Yes  No  
Other \_\_\_\_\_

### Integumentary

Skin rash  Yes  No  
Boils  Yes  No  
Persistent itch  Yes  No  
Other \_\_\_\_\_

### Eyes

Blurred vision  Yes  No  
Double vision  Yes  No  
Pain  Yes  No  
Other \_\_\_\_\_

### Musculoskeletal

Joint pain  Yes  No  
Neck pain  Yes  No  
Back pain  Yes  No  
Other \_\_\_\_\_

### Allergic/Immunologic

Hay fever  Yes  No  
Drug allergies  Yes  No  
Other \_\_\_\_\_

### Ear/Nose/Throat/Mouth

Ear infection  Yes  No  
Sore throat  Yes  No  
Sinus problems  Yes  No

### Neurological

Tremors  Yes  No  
Dizzy spells  Yes  No  
Numbness/tingling  Yes  No  
Other \_\_\_\_\_

### Genitourinary

Urine retention  Yes  No  
Painful urination  Yes  No  
Urinary frequency  Yes  No  
Other \_\_\_\_\_

### Endocrine

Excessive thirst  Yes  No  
Too hot/cold  Yes  No  
Tired/sluggish  Yes  No  
Other \_\_\_\_\_

### Respiratory

Wheezing  Yes  No  
Frequent cough  Yes  No  
Shortness of breath  Yes  No  
Other \_\_\_\_\_

### Gastrointestinal

Abdominal pain  Yes  No  
Nausea/vomiting  Yes  No  
Indigestion/heartburn  Yes  No

### Hematologic/Lymphatic

Swollen glands  Yes  No  
Blood clotting problem  Yes  No  
Other \_\_\_\_\_

### Cardiovascular

Chest pain  Yes  No  
Varicose veins  Yes  No  
High blood pressure  Yes  No  
Other \_\_\_\_\_

### Psychological

*Are you feeling generally satisfied with your life?*  
 Yes  No  
*Do you feel severely depressed?*  
 Yes  No  
*Have you considered suicide?*  
 Yes  No

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

## **Urologic Consultants, P.C. Financial Policy**

*We are dedicated to providing the best possible care to your family, and we want you to completely understand our financial policies.*

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Cash, Check, Visa, MasterCard and Discover.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor; in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurance, we will refund any overpayment to you.
3. We have made prior arrangement with many insurance companies and other health plans to accept any assignment of benefits. We will bill them, but you are required to pay a co-payment and/or deductible at the time of your visit.
4. If you are insured by a plan that requires services to be authorized by your Primary Care Provider, you will be responsible for obtaining the authorization prior to your appointment. Should you request medical treatment from our practice without authorization from your Primary Care Provider, you will be responsible for payment at the time of service.
5. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
6. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
7. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
8. I authorize payment of medical benefits by the insured directly to Urologic Consultants, P.C. I also request payment of government benefits directly to the party who accepts assignment.
9. I also understand, according to the State of Michigan, Department of Health, Act 488 of 1988, that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from myself, an HIV and Hepatitis-B (BBV blood test) will be performed.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_