The Urology Group

New Patient Health History (page 1 of 3)

Name:_________________________________ Today's Date:______________________________
Date of Birth: ___________________________ Age:____
Primary Care Doctor:_____________________ Primary Care Phone #:______________________
Referring Doctor:_______________________ Referring Doctor Phone #:___________________

Preferred Pharmacy (if known) (name, city, phone #)______________________________________

CHIEF COMPLAINT

What is the main reason you are seeing the doctor today? ___________________________
____

Please fill in below, or attach list if available.

ALLERGIES (please list all medication allergies and those to shellfish, etc.):

____

If no allergies, check here □

MEDICATIONS (please list all meds including over-the-counter meds, supplements and vitamins): ____
____
____

If no medications, check here □

MEDICAL PROBLEMS:

__Heart Disease
__Diabetes
__High Cholesterol
__High Blood Pressure
__Low Blood Pressure
__Stroke
__COPD/Emphysema
__Asthma
__Bronchitis
__Hepatitis
__Renal Disease
__Thyroid Disorders
__Chronic Urinary Tract Infections
__Arthritis
__Anemia
__Epilepsy
__Blood Transfusion
__Plasma Transfusion
__Glaucoma
__Mitral Valve Prolapse
__Migraine Headaches
__Infectious Mono
__HIV
__Eczema
__Hemorrhoids
__Tuberculosis
__Other:___________________

If no medical problems, check here □

SURGERIES:

__Tonsillectomy
__Wisdom Tooth
__Appendectomy
__Gallbladder Surgery
__Tubal Ligation
__C-Section
__D&C
__Hysterectomy
__Vasectomy
__Shoulder Surgery
__Knee Surgery
__Laparoscopy
__Hernia Repair
__Colonoscopy
__Other:___________________

If no prior surgeries, check here □

WEIGHT: _________________ HEIGHT: ____________________

When was your last EKG?________________________Where? ____________________
When was your last chest x-ray?___________________Where? ____________________

NAME:___________________________________ **DOB:**__________________

SOCIAL HISTORY (*Please check)*
Occupation: ____
Marital status: Single Married Separated Divorced Widowed

Tobacco Use:
- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Smoker Current Status Unknown
- ☐ Current Smokeless Tobacco User
- ☐ Unknown if ever smoked
- ☐ Exposure Secondhand Smoke

Do you drink alcohol? ☐ No ☐ Yes ☐ Prior History of abuse
What is your caffeine use: ☐ No ☐ 1-2 cups/day ☐ More than 3 cups/day
Do you use street drugs? ☐ No ☐ Yes

FAMILY HISTORY

	Father	Mother	Brother	Sister	PGF*	PGM*	MGF*	MGM*
Prostate Cancer								
Renal Cancer								
Bladder Cancer								
Testicular Cancer								
Heart Attack								
Heart Disease								
Stroke								
High Blood Pressure								
High Cholesterol								
Diabetes								
Kidney Disease								
Urinary Stones								
Cystic Fibrosis								
Tuberculosis								
Other Cancer type: ____________								
Other Family Hx:______________								

If there is no family history of any of the above, check here ☐

If family history is not available (unknown or unobtainable), please check here ☐

* PGF – Paternal grandfather (father's father)
PGM – Paternal grandmother (father's mother)
MGF – Maternal grandfather (mother's father)
MGM – Maternal grandmother (mother's mother)

MEDICAL HISTORY
Do you now, or have you had any problems related to the following symptoms:
If not checked, it will mean that you **do not** have that symptom or condition.

General
__Fatigue
__Night Sweats
__Chills
__Weight Gain
__Weight Loss

Skin
__Ulcers
__Rash
__Itching
__Lesions

Head
__Chronic Headaches
__Head Injury/Trauma

Eyes
__Vision Loss
__Double Vision
__Visual Disturbances

Ear, Mouth, Nose And Throat
__Ear Ringing
__Nosebleeds
__Hoarseness
__Decreased Hearing
__Bleeding from Gums

Respiratory
__Chronic Cough
__Wheezing
__Difficulty Breathing

Heart
__Chest Pain
__Murmur (req antibiotics)
__Palpitations

Gastrointestinal
__Constipation
__Diarrhea
__Nausea
__Vomiting
__Rectal Bleeding

Urinary
__Blood in Urine
__Incontinence
__Kidney Stones
__Frequency
__Urgency
__Venereal Disease/STDs

Muscular-Skeletal
__Back Pain
__Joint Pain
__Joint Swelling
__Muscle Weakness
__Muscular Pain or Tenderness

Neurological
__Dizziness
__Seizures
__Tremor

Psychiatric
__Anxiety
__Depression
__Mood Changes

Endocrine
__Appetite Changes
__Sexual Dysfunction

Hematology
__Easy Bruising
__Prolonged Bleeding

If none of the above symptoms, check here □

NAME:______________________________________ DOB:____________________

THE UROLOGY GROUP

LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

Date______________________________

LAST NAME		FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY NUMBER		SEX		PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*		STATUS *(please circle one)* Single Married Divorced Widowed Partner		STUDENT *(please circle one)* No Full Time Part Time
SMAILING ADDRESS		CITY/STATE		ZIP CODE
HOME PHONE *(include area code)*		WORK PHONE		CELL PHONE
RACE *(please circle one)* White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/Alaska Native		ETHNICITY *(please circle one)* Hispanic or Latino Not Hispanic or Latino Unknown		PREFERRED LANGUAGE English Spanish Or other: ________________________
EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER
PREFERRED PHARMACY	PHARMACY PHONE NUMBER		***PATIENT EMAIL ADDRESS***	

WHO REFERREDF YOU TO THIS PRACTICE ____

PRIMARY CARE PHYSICIAN (1ST/LAST NAME) ____ PHONE ______________________________________

CONTACT/GUARANTOR INFORMATION

CONTACT *(please circle at least one)* Emergency Contact Next of Kin Insured Authorized to Seek Treatment		LAST NAME	FIRST NAME		MIDDLE INITIAL
SSN *(social security number)*	DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS	
MAILING ADDRESS		CITY/STATE	ZIP CODE	HOME PHONE	
EMPLOYER		WORK PHONE		JOB TITLE	

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT *(please circle at least one)* **Guarantor** Emergency Contact Next of Kin Insured Authorized to Seek Treatment		LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)*	DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
MAILING ADDRESS		CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER		WORK PHONE		JOB TITLE

Over →

INSURANCE POLICY INFORMATION

POLICY NUMBER	GROUP ID			EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE		COPAYMENT AMOUNT Office: $_________ Specialist: $__________
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS			PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE	
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSCIAN (pcp) &/or REFERRING PHYSICIAN			

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID			EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE		COPAYMENT AMOUNT Office: $_________ Specialist: $__________
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS			PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE	

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

____ ____________________

Print Name **Date**

____

Signature

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it

____ ____________________

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis **Date**

____

Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent

LOUDOUN MEDICAL GROUP/THE UROLOGY GROUP
AUTHORIZATON TO DISCLOSE HEALTH INFORMATION

ADDITIONAL CONTACT INFORMATION

Please be advised. We cannot give information to anyone without your written consent. I authorize The Urology Group to speak with the person(s) listed below regarding my medical care.

NAME	PHONE	RELATIONSHIP

I authorize The Urology Group to leave a voice mail message at the following number(s). Messages may at times include some protected health information, including appointment reminders, test results and instructions. I understand that with my signature I am authorizing the release of oral communication by The Urology Group to this voice mail number(s).

HOME	CELL	WORK
SIGNATURE	DATE	

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

____
Patient Name

I have received a copy of Loudoun Medical Group's Notice of Primary Practices and understand that the notice describes how my/the patient's medical information may be used and now access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

Signature: ____

Date: ____

Relationship to Patient ____
(If Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledge, but was unable to do so as documented below:

Date: __________________ Staff Initials: _______ Reason: Refused to sign Other: