## LIMESTONE UROLOGY ASSOCIATES

**101 FITNESS WAY SUITE 2300**

**ATHENS AL, 35611**

| LAST NAME | FIRST | MI |
|---|---|---|
| SOCIAL SECURITY # | DATE OF BIRTH | AGE |
| MARITAL STATUS<br>□ S □ M □ D □ W □ Sep | RACE<br>□ Caucasian □ Black □ Hispanic □ Asian □ Other | |
| STREET ADDRESS | | |
| CITY | STATE | ZIP |
| PATIENT'S PHONE # | WORK PHONE # | CELL PHONE # |
| EMAIL ADDRESS: | | |

| PRIMARY CARE PHYSICIAN | OTHER PHYSICIAN |
|---|---|
| PHARMACY | |

| PRIMARY INSURANCE CO. | CO- PAY AMOUNT | CONTRACT # | GROUP # |
|---|---|---|---|
| NAME OF CARDHOLDER | SS # | DOB | RELATIONSHIP TO PATIENT<br>□ Spouse □ Parent □ Other |
| SECONDARY INSURANCE CO. | | CONTRACT # | GROUP # |
| NAME OF CARDHOLDER | SS # | DOB | RELATIONSHIP TO PATIENT<br>□ Spouse □ Parent □ Other |

| PATIENT'S EMPLOYER | EMPLOYER PHONE # |
|---|---|
| SPOUSE'S EMPLOYER (parent's employer, if minor) | PHONE # |
| EMERGENCY CONTACT | RELATIONSHIP TO PATIENT |
| PHONE # | |

### PLEASE READ AND SIGN INSURANCE AUTHORIZATION AND ASSIGNMENT

We invite you to discuss frankly with us any questions regarding our services. Our office policy requires payment in full for all medical services rendered at the time of visit, unless other arrangements have been made. If the account is not paid within 90 days of the date of service, and no financial arrangement has been made, you will be responsible for any expenses incurred in collecting your account. I hereby authorize the physician and/or supplier to release any information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

**Signature of Responsible Person** ___________________________________ **Date** ________________________

**LIMESTONE UROLOGY ASSOCIATES**

**DR. SAMUEL J. TROTTER**

**DR. JOHN L. HINSON**

**101 FITNESS WAY SUITE 2300**

**ATHENS, AL 35611**

**DATE:** ________________

**NAME:** ____________________________ **DOB:** ___________________

**REASON FOR VISIT (please specify):** _________________________________________________

__________________________________________________________________________________________

**Drug Allergies:** □ **No Drug allergy (please check if no drug allergy)**

| | | **Reaction(s)** |
|---|---|---|
| **1.** | _______________________________ | _________________________________________ |
| **2.** | _______________________________ | _________________________________________ |
| **3.** | _______________________________ | _________________________________________ |
| **4.** | _______________________________ | _________________________________________ |
| **5.** | _______________________________ | _________________________________________ |

**Current Medications (including over the counter medicines and dosages):**

| | | | |
|---|---|---|---|
| **1.** | _______________________________ | **2.** | __________________________________ |
| **3.** | _______________________________ | **4.** | __________________________________ |
| **5.** | _______________________________ | **6.** | __________________________________ |
| **7.** | _______________________________ | **8.** | __________________________________ |
| **9.** | _______________________________ | **10.** | __________________________________ |

**Past Medical History: (please check if applicable)**

**YES NO**

| | | | | | |
|---|---|---|---|---|---|
| □ | □ | **congestive heart failure** | □ | □ | **acute renal failure** |
| □ | □ | **coronary artery disease** | □ | □ | **chronic renal failure** |
| □ | □ | **high blood pressure** | □ | □ | **polycystic kidney disease** |
| □ | □ | **heart attack (MI)** | □ | □ | **kidney stone** |
| □ | □ | **chronic bronchitis** | □ | □ | **hemolytic anemia** |
| □ | □ | **COPD** | □ | □ | **iron deficiency anemia** |
| □ | □ | **hepatitis** | □ | □ | **prostate cancer** |
| □ | □ | **Diabetes, type 1** | □ | □ | **kidney cancer** |
| □ | □ | **Diabetes, type 2** | | | |

**SURGICAL HISTORY:** **WHEN**

□ **NO SURGERIES**

**1.** ___________________________________ ____________________________

**2.** ___________________________________ ____________________________

**3.** ___________________________________ ____________________________

**4.** ___________________________________ ____________________________

**5.** ___________________________________ ____________________________

**FAMILY HISTORY:** **DISEASE/CONDITIONS**

**FATHER:** __________________________________________

**MOTHER:** __________________________________________

**SIBLINGS:** __________________________________________

**DAUGHTER:** __________________________________________

**SON:** ______________________________________________

**MATERNAL GRANDFATHER:** ______________________________________________

**MATERNAL GRANDMOTHER:** ______________________________________________

**PATERNAL GRANDFATHER:** ______________________________________________

**PATERNAL GRANDMOTHER:** ______________________________________________

**OTHER BLOOD RELATIVE:** ______________________________________________

**<u>SOCIAL HISTORY:</u>**

**OCCUPATION:** ______________________________________

**MARITAL STATUS:** □ Single □ Married □ Separated □ Divorced □ Widowed

**CHILDREN:** □ YES □ NO # OF CHILDREN: ___________ AGES: ____________

**SMOKING HISTORY:**

□ current smoker □ former smoker □ never smoked Quit date: _________________________

□ cigarette □ cigar □ pipe □ smokeless tobacco

**<u>CAFFEINE:</u>**

□ None

□ coffee amount: ______________

□ tea amount: ______________

□ soda amount: ______________

□ chocolate amount: ______________

**<u>ALCOHOL:</u>**

□ non drinker □ socially □ rarelyamount: _____________ type of alcohol: ___________

**<u>SUBSTANCE ABUSE HISTORY:</u>**

□ None □ Amphetamines □ Barbiturates □ Benzodiazepines □ Cocaine □ Ecstasy

□ Hallucinogens □ Heroin □ Inhalants □ LSD □ Marijuana □ Mescaline

□ **Narcotics** □ **Opium** □ **PCP** □ **Psilocybin (mushroom)** □ **Sedatives** □ **Other: __________**

**MENTAL HEALTH HISTORY:**

□ **None**

□ **Anxiety Disorder** □ **Mood Disorder** □ **Eating Disorder** □ **Sexual Disorder**

□ **Schizophrenia / Psychosis** □ **Sleep Disorder** □ **Depression** □ **Other ______________**

**COMMUNICABLE DISEASE/ REPORTABLE DISEASE HISTORY:**

□ **None** □ **Sexually Transmitted Diseases (STD)** □ **Common reportable diseases (non STDs)**

□ **Rare reportable diseases** □ **Environmental exposures**

**REVIEW OF SYSTEMS** Please indicate below if you are **CURRENTLY** experiencing any of these symptoms:

**CONSTITUTIONAL/GENERAL**

| YES | NO | |
|---|---|---|
| □ | □ | Chills |
| □ | □ | Fever |
| □ | □ | Unintentional weight gain |
| □ | □ | Unintentional weight loss |

**Eyes**

| YES | NO | |
|---|---|---|
| □ | □ | Glaucoma |
| □ | □ | Cataracts |
| □ | □ | Glasses/Contacts |

**Gastrointestinal**

| YES | NO | |
|---|---|---|
| □ | □ | Abdominal pain |
| □ | □ | Constipation |
| □ | □ | Diarrhea |
| □ | □ | Heartburn |
| □ | □ | Nausea |
| □ | □ | Vomiting |

**Cardiovascular**

| YES | NO | |
|---|---|---|
| □ | □ | Irregular heart beat |
| □ | □ | Palpitations |
| □ | □ | High blood pressure |
| □ | □ | Varicose veins |

**Endocrine**

| YES | NO | |
|---|---|---|
| □ | □ | Diabetes |
| □ | □ | Thyroid disorder |

**Psychiatric**

| YES | NO | |
|---|---|---|
| □ | □ | Anxiety |
| □ | □ | Sleep Disturbance |
| □ | □ | Depression |

**Musculoskeletal**

| YES | NO | |
|---|---|---|
| □ | □ | Joint pain |
| □ | □ | Back pain |
| □ | □ | Neck pain |

**Respiratory**

| YES | NO | |
|---|---|---|
| □ | □ | COPD |
| □ | □ | Chronic Cough |
| □ | □ | Acute Cough |
| □ | □ | Shortness of Breath |
| □ | □ | Exposure to TB |

**Genitourinary**

| YES | NO | |
|---|---|---|
| □ | □ | Difficulty urinating |
| □ | □ | Blood in urine |
| □ | □ | Unprotected sex |
| □ | □ | Urinary retention |
| □ | □ | Impotence |
| □ | □ | Urinary frequency at night |
| □ | □ | Urinary frequency |
| □ | □ | Urinary leakage |
| □ | □ | Urinary stream change |

**Hematologic/Lymphatic**

| YES | NO | |
|---|---|---|
| □ | □ | Easy Bruising |
| □ | □ | Excessive bleeding |
| □ | □ | History of blood transfusion |

**Patient Signature:**_____________________________________________

**Physician Signature:**____________________________________________