TriCounty Urology
Gus S Freiha, MD ● Patrick A Williams, MD
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NEW PATIENT PROFILE

PLEASE FILL OUT THIS QUESTIONNAIRE.
ASK THE STAFF IF YOU NEED HELP.

Date ___/___/___ DOB ___/___/_____

Name _____

Gender - Male Female Other

SSN _____

Address _____

City _____ Zip _____

Home Phone _____

Cell Phone _____

Text Communication: Yes No

Your Employer _____ Work phone _____
Spouse/Guardian's Name _____ Spouse Work phone _____
Name of your Family Doctor _____ Phone:_____
Name of Doctor that sent you _____ Phone:_____
In Case of Emergency Call (other than above) _____
_____

Please provide the following information so we can file a claim for you.
Are you, the patient, also the insurance policyholder? If yes, skip next section. If no, please fill out:
Policyholder's name/address _____
Policyholder's SSN _____ DOB _____
Policyholder's relationship to you:_____
Policyholder's employer _____

Email Address for portal access: _____
What is your preferred **LOCAL** pharmacy**?** _____
What is your preferred **MAIL ORDER** pharmacy? _____

What is your preferred language? English Spanish Other:_____
What is your race? African American Hispanic Caucasian Other:_____
What is your ethnicity? Hispanic/Latino Non Hispanic/Latino Other:_____

I attest that the information above is correct to the best of my knowledge.
I acknowledge that I have given this office the right to file with my insurance for payment for the services rendered.
I agree to pay any balance remaining on the account after my insurance has paid or denied payment (insurance co-payment, if applicable, is due at the time of the office visit).

At times, it is necessary for our physicians to obtain the patient's medication history that is available at participating pharmacies. I consent to allow access to all my prescription history to my physicians.

Signature _____

NAME_____ DOB_____

What problem(s) has brought you here to see the Doctor?

_____

_____

How tall are you? _____ feet _____ inches

Do you take any MEDICATIONS or PILLS? Include over-the-counter drugs

Medicine or Pill Name	Size/Dose (ex. 50 mg)	How many per day	Why do you take this?

Do you have any ALLERGIES to medications, contrast/dye, or foods? Please list below

Medicine, Food, etc.	What happens if you take or eat this?

NAME_____ DOB_____

Do you have any MEDICAL PROBLEMS or ILLNESSES? Please check below

- ☐ None
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune disease
- ☐ Sleep apnea
- ☐ Heart disease
- ☐ Cancer of breast
- ☐ Cancer of colon
- ☐ Cancer of lung
- ☐ Cancer of prostate
- ☐ Cancer of ovary
- ☐ Cancer of uterus
- ☐ Cancer of cervix
- ☐ Congestive heart failure
- ☐ Crohn's disease
- ☐ Cirrhosis of liver
- ☐ COPD/emphysema
- ☐ Depression
- ☐ Diabetes, childhood
- ☐ Diabetes, adult
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Blood clot in legs
- ☐ Reflux/heartburn
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ High cholesterol/lipids
- ☐ High blood pressure
- ☐ High thyroid
- ☐ Low thyroid
- ☐ Kidney stones
- ☐ Heart attack
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Pulmonary Embolus
- ☐ Circulation problems
- ☐ Kidney failure
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Tuberculosis

☐Other_____

_____

Have you ever had any SURGERIES or PROCEDURES? Please check below

- ☐ None
- ☐ Amputation
- ☐ Appendectomy
- ☐ Back surgery-neck
- ☐ Back surgery-mid back
- ☐ Back surgery-low back
- ☐ Breast augmentation
- ☐ Breast reduction
- ☐ Tubes tied for birth control
- ☐ Caesarian section
- ☐ Open heart surgery
- ☐ Carotid surgery
- ☐ Carpal tunnel repair
- ☐ Cataracts
- ☐ Gallbladder removal
- ☐ Colon removal
- ☐ Brain surgery
- ☐ Kidney stone lithotripsy
- ☐ Gastric bypass
- ☐ Hemorrhoidectomy
- ☐ Hernia repair-groin
- ☐ Hernia repair-abdominal
- ☐ Hip replacement
- ☐ Hysterectomy-abdominal
- ☐ Hysterectomy-vaginal
- ☐ Knee scope
- ☐ Knee replacement
- ☐ Laparoscopy
- ☐ Mastectomy
- ☐ Kidney removal
- ☐ Ovary removal
- ☐ Pacemaker
- ☐ Prostate removal, complete
- ☐ Shoulder scope
- ☐ Shoulder rotator cuff
- ☐ Stents in heart
- ☐ Tonsillectomy
- ☐ Thyroid removal
- ☐ Bladder tumor removal
- ☐ Prostate surgery (scope)
- ☐ Kidney stone removal/stent
- ☐ Bladder for incontinence
- ☐ Heart valve replacement
- ☐ Vasectomy

☐Other_____

_____

NAME_____ DOB_____

Do any illnesses run in your immediate FAMILY? (Mother, Father, Brother, Sister, Son, Daughter)

□ None □ Unknown Why? _____

□ Anesthetic complications Who? _____
□ Asthma Who? _____
□ Cancer of cervix Who? _____
□ Cancer of colon Who? _____
□ Cancer of breast Who? _____
□ Cancer of lung Who? _____
□ Cancer of ovary Who? _____
□ Cancer of prostate Who? _____
□ Cancer of uterus Who? _____
□ Other cancers Who? _____
□ COPD/emphysema Who? _____
□ Diabetes Who? _____
□ Heart disease Who? _____
□ High cholesterol Who? _____
□ High blood pressure Who? _____
□ Kidney disease Who? _____
□ Stroke Who? _____

□Other_____
_____

NAME_____ DOB_____

Do you currently smoke? Yes ___ No___
If yes, how Much? _____
When did you start? _____
Did you smoke in the past? Yes ___ No___
If yes, when did you quit? _____
When did you start? _____
How much did you smoke? _____
Do you use other forms of tobacco? Yes ___ No
If yes, what? _____

Do you drink alcohol? Yes ___ No ___
If yes, what do you drink? _____
How many drinks per day _____ per week _____

Do you use any illegal drugs? Yes ___ No___
If yes, what? _____

Do you exercise regularly? Yes ___ No___
If yes, what kind? _____
How many days per week? _____

NAME_____ DOB_____

REVIEW OF SYSTEMS

Do you have or recently had?	Yes	No	Don't know	Describe
Recent fever or chills				
Sweats				
Fatigue or weakness				
Loss of appetite				
Weight loss				
Vision loss				
Blurring of vision				
Double vision				
Eye pain				
Sensitivity to light				
Hearing loss				
Ear pain				
Ringing in ears				
Nose bleeds				
Nasal congestion				
Sore throat				
Hoarseness				
Chest pain or angina				
Irregular heartbeat/racing heart				
Fainting				
Shortness of breath with activity				
Swelling of ankles/legs				
Shortness of breath				
Cough				
Blood in sputum				
Wheezing				
Snoring				
Nausea				
Vomiting				
Diarrhea				
Constipation				
Abdominal pain/cramping				
Blood in stool				
Vomiting blood				
Jaundice				
Indigestion/heartburn				
Back pain				
Joint pain				
Muscle cramps				
Muscle weakness				
Arthritis				
Sciatica				

NAME_____ DOB_____

Do you have or have you ever had?	Yes	No	Don't know	Describe
Rash				
Itching				
Dry skin				
Paralysis				
Numbness				
Seizures				
Tremors				
Vertigo				
Frequent headaches				
Cold intolerance				
Heat intolerance				
Excessive thirst				
Excessive hunger				
Abnormal bruising				
Abnormal bleeding				
Enlarged nodes				
Hay fever/seasonal allergies				
Persistent infections				
HIV exposure				
Depression				
Anxiety				
Memory loss				
Leakage of urine				
Pain with urination				
Blood in urine				
Frequent need to urinate				
Waking up at night to urinate				
Difficulty passing urine				
Kidney stones				

FOR MEN ONLY

Do you have or have you ever had?	Yes	No	Don't know	Describe
Discharge from penis				
Genital sores/sexually transmitted disease				
Decreased libido				
Problems with erections				
Testicle pain or lump				

FOR WOMEN ONLY

Do you have or have you ever had?	Yes	No	Don't know	Describe
Vaginal discharge				
Vaginal bleeding				
Could you be pregnant now?				

Comal Urology Associates

Gus S. Freiha, M.D.
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Michael F. Sedlak, M.D.
Adult and Pediatric Urology

MEDICAL INFORMATION RELEASE FORM

Patient Name _____ DOB _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check all that apply)

( ) Home Telephone _____
- ( ) OK to leave message with detailed information.*
- ( ) Leave message with call back number only.

( ) Work Telephone _____
- ( ) OK to leave message with detailed information.*
- ( ) Leave message with call back number only.

( ) Written communication
- ( ) Mail to my home address.
- ( ) Mail to my work address.
- ( ) FAX to this number _____.

( ) OTHER _____
_____

* ONLY IF ANSWERING MACHINE IDENTIFIES YOU BY NAME.

Please list below individuals to whom we may release ANY medical information

Date	Disclose to Whom	Phone Number	Relationship

_____ _____
Patient/Guardian Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices For TriCounty Urology, P.A.

Patient Name: _____

Date of Birth: _____

I acknowledge that TRICOUNTY UROLOGY, P.A. has provided me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notices of Privacy Practices and ask questions.

Patient Signature

_____

Date _____

Personal Representative Signature (if applicable)

_____

Relationship to patient _____