Date:_____

Southeast Texas Urology Associates, L.L.P.

Referring/Primary Physician:_____

Name:_____ Social Security #: _____

Mailing Address: _____

City: _____ State:_____ Zip: _____

Date of Birth:_____ Gender: M / F Marital Status (circle one) S M D W

Race: _____ Ethnicity: _____ Preferred Language: _____

Home #:_____ Work #:_____ Cell #: _____

Email:_____

Do you want access to your patient portal? Y N

Emergency Contact: Name: _____ Relationship: _____

Address:_____Phone #: _____

City:_____State:_____ Zip: _____

May the physician discuss your medical history with this person? Y N

Emergency Contact (2): Name:_____ Relationship:_____

Phone #: _____

May the physician discuss your medical history with this person? Y N

Responsible Party Information (if different from patient):

Name: _____Relationship: _____

Date of Birth: _____Phone#:_____

Address: _____

City:_____ State:_____ Zip: _____

Insurance Information:

Primary Insurance Company: _____

Secondary Insurance Company:_____

It will be my responsibility to call for results and all lab and x-rays through this office if not informed in a timely manner.

Signature _____

I authorize all medical and/or surgical treatment to be rendered by Dr. J. Denton Harris, Dr. John Henderson, Dr. Steven A. Socher, Dr. Jenny Nguyen, Benjamin Strahan, FNP-C and Anthony Scoggins, ACNP-BC and I assume financial responsibility. I assign all benefits to be paid to Southeast Texas Urology Associates - Dr. J. Denton Harris, Dr. John Henderson, Dr. Steven A. Socher, Dr. Jenny Nguyen, Benjamin Strahan, FNP-C and Anthony Scoggins, ACNP-BC under my medical Insurance Program and give my authorization to release records if necessary, including DX and treatment to Insurance Company, physicians, etc. I understand that I am entitled to receive a copy of my medical records.

Signature _____

Appointment Type: (Circle) NEW PATIENT FOLLOW UP **Date**_____

Account#_____

Patient Name: _____ **DOB:** _____ **Age:** _____

Height: _____ **Weight:** _____

Reason for today's visit:_____

_____

How long have you had these symptoms? _____

1. Primary Doctor:_____ Preferred Pharmacy: _____ Mail Order: _____
2. Are you presently taking: (Circle) Coumadin - Aspirin- Ecotrin - Persantine - Glucophage
   Inhalers - Ticlid - Plavix - St. John's Wort
3. Have you had a: (Circle One) Heart Attack **Yes/No** Stroke **Yes/No**
   Diabetes **Yes/No** Emphysema/Asthma **Yes/No**
4. Other Medical Problems _____
5. List previous surgeries_____

   _____
6. Allergies _____

   Family History of: (Please Circle)

   Ovarian Cancer **Yes/No** Kidney Cancer **Yes/No** Bladder Cancer **Yes/No**

   Kidney Stones **Yes/No** Kidney Problems **Yes/No** Diabetes **Yes/ No**
7. Occupation: _____
8. Tobacco Use: (Please Circle) Cigarettes/Cigar **Yes/No** Dipping/Chewing **Yes/No**

   Did you ever smoke? **Yes/ No** When did you quit?_____ How Long did you smoke:_____
9. Do you drink Alcohol? (Please Circle) **Yes/ No** **Social Light or Moderate**
10. Pneumonia Immunization? (Please Circle) **Yes / No** When? _____
11. Last colonoscopy? _____

Please Circle Yes or No to Each Symptom

Y/N Fever
Y/N Chills
Y/N Weight Loss
Y/N Weight Gain
Y/N Night Sweats
Y/N Malaise (feeling poorly)
Y/N Abdominal Pain
Y/N Constipation
Y/N Diarrhea
Y/N Nausea
Y/N Vomiting
Y/N Swelling of Legs
Y/N Chest Pain
Y/N Irregular Heartbeat
Y/N Vaginal Bleeding
Y/N Kidney (flank) Pain
Y/N Shortness of Breath
Y/N Pelvic Pain
Y/N Vaginal Discharge
Y/N Vaginal Delivery
If yes, how many_____

Y/N Urethral Discharge
Y/N Blood in Urine
Y/N Leaking of Urine
Y/N Urgency to Void
Y/N Voiding at Night
Y/N Slow Stream
Y/N Difficulty Starting Stream
Y/N Incomplete Emptying of Bladder
Y/N Masses Protruding from Vagina
Y/N Straining to Urinate
Y/N Burning with Urination
Y/N Loss of Sexual Interest
Y/N Painful Intercourse
Y/N Back Pain/Surgery
Y/N Sore Muscles
Y/N Arthritis
Y/N Hepatitis
Y/N Reflux
Y/N Glaucoma
Y/N Blurry Vision
Y/N Cataracts

Y/N Blind
Y/N Hearing Loss
Y/N Nasal Stuffiness
Y/N Dry Mouth
Y/N Sore Throat
Y/N Rash
Y/N Dry Skin
Y/N Bruising
Y/N Lesions/Ulcers
Y/N Dizziness
Y/N Forgetfulness
Y/N Migraines
Y/N Loss of Balance
Y/N Depression
Y/N Swollen Glands
Y/N Bleeds Easily
Y/N Blood Clots
Y/N Wheezing
Y/N Cough
Y/N Joint Problems

Current Medications:

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