JAMIE VANOVEREN, D.O.
CLAY M. PENDLETON, M.D.

Patient Information

(This information is necessary for our files and will be considered CONFIDENTIAL)

Last Name_____ First Name _____ Middle Name_____ Birth date ____/____/_____

Mailing Address_____ City _____ State _____ Zip _____

Phone (____)_____ Cell Phone (____)_____ Social Security #_____ Sex_____

Marital Status: **S** ☐ **M** ☐ **D** ☐ **W** ☐ Preferred Language **English** **Other** _____**Decline** ☐

Race _____**Decline** ☐ Ethnicity: **Hispanic** **Non-Hispanic** **Decline**☐

Preference for appointment reminders **Printed** **Electronic** **Phone** **Email address**_____

Family Physician_____Pharmacy_____Employer_____

Spouse's Name _____ Phone _____

Emergency Contact (not living with you) Name_____ Phone_____

RESPONSIBLE PERSON FOR ACCOUNT IF DIFFERENT THAN PATIENT

Name _____ Social Security # _____ Birth date_____

Address_____ City_____ State____ Zip_____ Phone(___)_____

INSURANCE INFORMATION IF DIFFERENT THAN PATIENT

IF YOU ARE NOT THE INSURED YOU ARE REQUIRED ** TO FILL OUT BELOW**

PRIMARY CARDHOLDER NAME_____ Birth date ____/____/_____

Relationship to Patient_____ SS#_____

FINANCIAL OBLIGATIONS AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to read and review Urology Clinic P.C.'s financial policy. I understand that I am responsible for payment in full of all charges incurred, including costs not covered by my insurance. It is the patient's responsibility to make sure we are in network with your insurance plan, **failure to do so may result in you being responsible for your entire bill.** I further understand I am responsible for contacting and/or following up with my insurance company should they not pay in a timely manner. Urology Clinic PC will charge a **$50 fee** for **No Show** of appointments or canceling appointment less than 24 business hours before scheduled appointment. I hereby acknowledge that I have been given the opportunity to read a copy of Urology Clinic P.C.'s **Financial obligations** and **Notice of Privacy Practices (HIPPA).**

* _____ _____

Signature of Patient **DATE**

AUTHORIZATION TO SHARE YOUR MEDICAL INFORMATION

I authorize Urology Clinic P.C. to share medical information with my designated person (e.g. your partner, spouse, relative or friend.) You can appoint several persons if you want to, or leave it blank. If someone calls or comes in to ask for any information about you, the name of this person must be on this form, if not; we cannot and will not give any information. Urology Clinic P.C. can release my health information of billing to the following.

(NAME of person)_____**Relation**_____

(NAME of person)_____**Relation**_____

* _____ _____

Signature of Patient **Date**

Today's Date _____/_____/_____

PATIENT HISTORY FORM

Name_____ Date of Birth _____/_____/_____

Chief Complaint (What is the main reason for your visit today? Please describe in Detail)

_____

_____

_____

Height ____ **feet**___**inches** **Weight**_____ **Pharmacy** _____

MEDICAL HISTORY

Allergies:

- ☐ None Known
- ☐ Sulfa
- ☐ Penicillin
- ☐ Other Antibiotic or medication

  _____

  _____
- ☐ IVP/CAT Scan Contrast
- ☐ Latex
- ☐ Foods

  _____

  _____

Previous Medical Illnesses:

Have you ever had any of the following?

- ☐ Asthma
- ☐ Emphysema
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart attack or heart condition
- ☐ Increased blood pressure
- ☐ Blood Disorder
- ☐ Ulcer Disease
- ☐ Gallbladder disease
- ☐ Stroke
- ☐ Thyroid condition
- ☐ Kidney stones / disease
- ☐ Any other condition not listed
- ☐ None of the above

Have you ever been hospitalized?

If so, when, where, and for what reason

_____

_____

_____

Have you ever had any operation?

If so, please list (dates if known)

_____

_____

_____

Social History:

Current smoker ☐ Former smoker ☐ Never ☐

Packs per day? _____ Years smoked? _____

Do you use marijuana? If yes how much_____

Any illicit drug use? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If Yes, how much? _____

Family History:

Has anyone in your family had any of the following diseases

Relation to you

- ☐ Hypertension _____
- ☐ Hyperlipidemia _____
- ☐ Coronary heart disease: _____
- ☐ Diabetes _____
- ☐ COPD _____
- ☐ Thyroid disease _____
- ☐ Kidney disease _____
- ☐ Kidney Stones _____
- ☐ Prostate cancer _____
- ☐ Breast cancer _____
- ☐ Other cancer _____
- ☐ None of the above

For Men Only: Prostate Symptom Score

Over the past month or so, how often have you had the following:

(0)=Never, (3)=half the time, (5)=always.

1. Felt as if bladder not empty after voiding 0 1 2 3 4 5
2. Need to urinate again within 2 hours 0 1 2 3 4 5
3. Stopped and started again while urinating 0 1 2 3 4 5
4. Found it difficult to postpone urination 0 1 2 3 4 5
5. Had a weak urinary stream 0 1 2 3 4 5
6. Had to push or strain to begin urination 0 1 2 3 4 5
7. Number of times you get up at night to urinate 0 1 2 3 4 5

Date of last PSA_____

Value of last PSA _____

Total Symptom Score_____

For Women Only: Number of live births _____

Type of delivery:

Vaginal: _____ Cesarean: _____

When was your last pap smear? _____

Patient Name: _____

Review of Systems: Do you currently have any problems related to the following systems?

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Other		
_____		
Eyes		
Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other		
_____		
Allergic/Immunologic		
Hay fever	Y	N
Drug allergies	Y	N
Other		
_____		
Neurological		
Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other		
_____		
Endocrine		
Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		
_____		
Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		
_____		
Cardiovascular		
Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Integumentary		
Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other _____		
Musculoskeletal		
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		
Ear/Nose/Throat/Mouth		
Ear infections	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other _____		
Genitourinary		
Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		
Respiratory		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		
Hematologic / Lymphatic		
Swollen Glands	Y	N
Blood clotting problems	Y	N
Other _____		
Psychological		
Are you generally satisfied with life?	Y	N
Are you severely depressed?	Y	N
Have you ever considered suicide?	Y	N
Other _____		

Reviewed by: _____ **Date:** _____

Patient Name_____ DOB _____

MEDICATIONS

Revised 9/25//2023