



Urology Consultants, Ltd.

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Welcome to our practice. To simplify the process on your first visit please complete the enclosed patient information forms prior to your arrival. Additionally, you will need to present a current insurance card upon your arrival. If your insurance requires a referral from your primary care physician it is your responsibility either to bring it with you, or to insure that it has been transmitted to us. We strongly encourage you to contact your insurance carrier to determine whether or not you need a referral for your visit to the urologist.

In order to help maintain health care costs we require all co-pays at the time of check-in. If you wish to acquaint yourself with our practice you may visit our website at www.ucl-stl.com.

We look forward to seeing you.

Sincerely,

The physicians and staff at Urology Consultants, Ltd.



Urology Consultants, Ltd.

Please complete the following questions:

1. Have you had any lab work or xrays done by your Primary Care Physician for anything related to your visit with us? We will need your medical records pertaining to any urological history and any xray films if done outside of Anderson Hospital.
2. Have you ever seen another urologist? If so, these records must be obtained prior to your office visit as well.
3. Have you been seen in any Emergency Room for your urological condition?
4. Please complete the enclosed forms and questionnaire prior to your visit with us and arrive 20 minutes before your scheduled appointment time.

Please call us in advance if you are having difficulty obtaining any of your records. We may be unable to see you without them and may need to reschedule your appointment.

Patient's Name: _____ Patient's Height: _____ Patient's Weight: _____

Reason For Visit/Chief Complaint: _____ Date Symptoms Began: _____

PAST SURGICAL HISTORY

Surgeries/Hospitalizations:	
1.	5.
2.	6.
3.	7.
4.	8.

Check box if list continues

Have You Ever Had A Problem With Anesthesia? No Yes:

Explain: _____

Medication/Vitamins/Supplements	Dose	Medication/Vitamins/Supplements	Dose	Medication/Vitamins/Supplements	Dose
1.		5.		9.	
2.		6.		10.	
3.		7.		11.	
4.		8.		12.	

Check box if list continues

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL/MEDICAL PROCEDURES? _____ YES _____ NO

ALLERGIES/TYPE OF REACTION

FAMILY HISTORY (Check all that apply.)

Diabetes Heart Disease Stroke High Blood Pressure
 Cancer Kidney Disease Anesthesia Problems Other _____

SOCIAL HISTORY

Tobacco Use: No Yes, Packs per day? _____ for _____ Years Stopped - When? _____
 Daily Alcohol Use: No Yes, Amount? _____ Coffee: No Yes, Amount? _____

PAST MEDICAL HISTORY

	No	Yes		No	Yes		No	Yes
Stroke or TIA			Depression			Emphysema		
Heart Attack			Panic Attack			Asthma		
Heart Murmur			Epilepsy			Tuberculosis		
High Blood Pressure			Reflux - (GERD)			Diabetes		
High Cholesterol			Ulcers			Cancer		
DVT or Blood Clots			Hypothyroid			Enlarged Prostate		
Bleeding Tendencies			Kidney Disease			HIV		
Anemia			Kidney Stones			Arthritis DJD		
Hepatitis - What Type			COPD					

REVIEW OF SYSTEMS

Symptom	No	Yes		No	Yes
Weight Loss			Heartburn		
Fever and/or Chills			Difficult Urination		
Double Vision			Pain or Burning on Urination		
Loss of Vision			Blood in Urine		
Loss of Hearing			Frequent Urge to Empty Bladder		
Severe Nose Bleeds			Loss of Urine when Laughing, Coughing, etc.		
Hoarseness			Weakness		
Frequent sore Throats			Frequent Itching		
Shortness of Breath with Exertion			Rashes		
Swelling of Feet or Ankles			Skin Cancer		
Sudden Changes in Rate of Heart Beat			Numbness/Tingling		
Pain or Pressure in Chest with Exertion			Seizures		
Awakened at Night Short of Breath			Memory Loss		
Asthma			Balance Problems		
Chronic Cough			Do you worry a lot?		
Coughing up Blood			Are you a nervous person?		
Frequent Chest or Bronchial Infections			Are you Frequently Unhappy or Depressed?		
Nausea or Vomiting			Excessively Thirsty, Hot, Cold, Sleepy		
Vomiting of Blood			Seasonal Allergies		
Any Change in Bowel Habits					

Doctor's Signature _____