Medical/Allergy Alerts

Medication Log

PLEASE GIVE US YOUR PHARMACY INFORMATION AND LIST ALL CURRENT MEDICATIONS.

Name_____ Date of Birth_____

Home Phone _____ Work Phone_____

Pharmacy_____ Pharmacy Phone_____

Date Rx	Name of Medication	Dosage	Qty.	Frequency	Refills	Stop Date

Review of Systems

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS?

CIRCLE YES OR NO

Please explain any Yes answers in the space provided

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
- Hey 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
- Other_____

Intgumentary
- 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 infection 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

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other_____

Psychological
- Are you generally satisfied with your life Y N
- Do you feel severely depressed Y N
- Have you ever considered suicide Y N
- Other_____

Physician use only: (comments/notes)

# answer	Level of service
0-1	1 or 2
2-9	3
10+	4 or 5

PATIENT HISTORY FORM

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT AT YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

Today's Date____/____/____ Date of Last Physical Exam____/____/____

Last Name_____First Name_____Middle_____

Social Security No._____Date Of Birth____/____/____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem
Abdomen Back Leg
Other_____

_____

_____

On a scale of 1-10, with 10 being the most severe,
Circle the number that best describes the problem?
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other_____

Does anything help or make the problem worse?
Moving around Standing up Lying on my side
Other_____

How long does the problem last?
30 minutes 1 hour It is always there
Other_____

Is anything else occurring at the same time?
Yes No If yes, please explain.
Nausea Rash Headaches
Other_____

Is the problem constant or variable?
Dull then Sharp Very sharp then leaves
Always there
Other_____

Does the problem interfere with your normal functions? Yes No If yes, please explain

_____

Physician use only: (comments/notes)

# answers	level of service
1-3	1 or 2
4+	3-5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, breast cancer, heart disease, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.
Illness Surgery Date

_____

_____

_____

Do you smoke? Y N
If yes, how much _____
Do you drink? Y N
If yes, how much?_____

Are you on any medications? Y N
(See medication log to list medications(last page)

_____

Are you on a special diet? Y N (If yes, please explain.)

_____

Do you have any drug allergies? Y N (If yes, please explain.)

_____

_____

Physician use only: (comments/notes)

# answer	level of service
0	1 or 2
1-2	3
3	4 or 5

LONESTAR UROLOGY
DR. ROBERT G. STROUD
PATIENT INFORMATION

Patient Name _____ Date: _____
Last/First/Middle

Sex M or F Marital Status S M W D Sep Social Security # _____

DOB _____ Age _____ E-mail: _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Mobile _____

Employer _____ Occupation _____

Employer's Address _____ City/State/Zip _____

Spouse/Parent's Name _____ Date of Birth _____

Employer _____ Occupation _____

Employer's Address _____ City/State/Zip _____

Work Phone ( ) _____ Social Security _____

Primary Insurance _____ Phone ( ) _____

Insured Name _____ ID # _____ Group Name or # _____

Insurance Address _____ City/State/Zip _____

Secondary Insurance Co _____ Phone ( ) _____

Insured Name _____ ID # _____ Group Name or # _____

Insurance Address _____ City/State/Zip _____

REFERRING PHYSICIAN _____ Phone _____

Address _____ City/State/Zip _____

Name and phone # of nearest relative not living with you _____

FINANCIAL RESPONSIBILITY

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring physician and to my insurance company. I allow electronic transmittal of my medical records as needed. I acknowledge full financial responsibility for services rendered by Dr. Robert G. Stroud. We will file to your insurance as a courtesy to you, the patient. If for any reason your insurance plan has preexisting conditions or does not cover any services provided by Dr. Stroud or his staff, you the patient are financially responsible .It is the patients responsibility to make sure we have correct insurance information, your place of residence, and contact information.

I understand that payment for services rendered **(including co-pays, Medicare co-insurance, deductibles)** are due at the time of service. I agree to pay all reasonable attorney fees and collections costs in the event of default of payment of my charges. I authorize and request that insurance payments be made directly to Dr. Robert G. Stroud. **I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.**

_____ _____

PATIENT SIGNATURE (PARENT IF PATIENT IS A MINOR) DATE