Riverview Urologic Associates – Health History

Patient Name: D.O.B.: SS#: _____
Address:
Today's Date :

Race (please circle one) Caucasian(white) African American(black) Asian

Native American Pacific American Other More than one race

Ethnicity (please circle one) Latino/Hispanic Other Refuse

Home Phone: Cell Phone: Work Phone:
E-Mail Address_____

Occupation_____ Employer_____

Work Address and Phone_____

Spouse's Name if married _____ Referring Physician_____

Alternative Contact Person & Phone #_____

Pharmacy Name & Phone #_____

Medications you are now taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you taking blood thinners? Yes No Aspirin? Yes No

Lovenox_____ Coumadin_____ Ticlid_____ Plavix_____ Vitamin E_____ Herbals_____

Are you being treated by a cardiologist? No Yes Name_____

Are you allergic to food or medications? No Yes (if yes, please list)

_____ _____ _____

_____ _____ _____

Patient Name:

Do you smoke (if yes, how much)? No Yes _____

Do you drink alcohol (if yes, how much)? No Yes _____

Have you lost weight recently (if yes, how much)? No Yes _____

Do you wear dentures? Yes No

Patient Name:
Do you have or have you been treated for any of the following?:

____Heart Attack	____High Blood Pressure	____Irregular Heart Beat
____Chest Pain (angina)	____Artificial Heart Valves	____Mitral Valve Prolapse
____Shortness of Breath	____Chronic Cough	____Breathing Trouble
____Emphysema	____Stroke	____Paralysis
____Muscle Weakness	____Seizures	____Arthritis
____Back Trouble	____Diabetes	____Hepatitis
____Cirrhosis	____Thyroid Problems	____Artificial Joints
____Rheumatic Fever	____Nervous Disorder	____Kidney Disease
____Anemia	____Blood Transfusions	____Heart Murmur
____Glaucoma	____Tuberculosis	____Hiatal Hernia
____Cancer		

____Other _____

List any previous surgeries and their dates:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you been told to take antibiotics prior to dental/surgical procedures? No Yes

If yes please explain_____

Have you ever had any problems with anesthesia? No Yes

If yes please explain_____

Reason for today's visit_____

_____

Patient Name:
Have you had any recent medical testing pertaining to today's visit? No Yes

What tests?_____

Where were they done?_____

Insurance Authorization

I request that payment of authorized insurance benefits be made either to me or on my behalf to Riverview Urologic Associates for any services furnished me by that physician or supplier. I authorize any holder or hospital of medical information about me to release any information needed to determine these benefits payable for related services.

Insured's Signature_____ Date_____