

Advanced Urology Medical Center

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Patient _____
Last Name First Name Middle Initial

Responsible Party (if a minor) _____

Home Phone (____) _____ Cell (____) _____

Street Address _____

City _____ State _____ Zip Code _____

Sex: M or F Birth Date _____ Marital Status: S M W D Other _____

Race: _____ (Optional) Primary Language _____

Social Security # _____

Primary Care/Referring Physician _____

Primary Care Phone # _____ Referring Phone # _____

Employment Status: Employed (FT) Employed (PT)
Self Employed Retired Not Employed

Employer _____ Student Status: FT – PT – None

Responsible Party _____ Relation: _____

In case of an emergency, who should be notified? _____

Phone # (____) _____ Relationship _____

Name of Primary Insurance _____ Member # _____

Name of Sec. Insurance (if any) _____ Member # _____

Pharmacy Name: _____ Phone # _____

Address: _____

.....
Insurance Assignment and Release

I certify that I have insurance coverage with _____
Name of Insurance Company (ies)

I understand that if my insurance benefits and/or eligibility are not approved by my health plan (HMO or PPO) then I am financially responsible and agree to pay for all charges related to services provided to the patient(s).

The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company (ies) and for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature _____

Parent or Guardians Signature (if minor) _____

NAME: _____
ACCT: _____

Advanced Urology Medical Center
1211 W. La Palma Ave. #502
Anaheim, CA 92801

MALE
UROLOGIC HISTORY

	YES	NO
Do you have any troubles urinating? (specify) _____ _____ _____	_____	_____
Do you urinate more than 5 times/day?	_____	_____
Do you get up at night to urinate?	_____	_____
How many times? _____ times.		
Do you find it hard to start urinating?	_____	_____
Do you find yourself straining to urinate?	_____	_____
How is your urine stream? Strong _____ Medium _____ Weak _____		
Does it take a longer time to urinate?	_____	_____
Is urination painful?	_____	_____
Is the pain Before _____ During _____ or After _____ urinating?	_____	_____
Do you have to hurry to reach the bathroom?	_____	_____
Do you leak urine if you don't reach the bathroom?	_____	_____
Do you feel pressure in the bladder area?	_____	_____
Is it relieved by urination?	_____	_____
Do you need to urinate again after a few minutes?	_____	_____
Is your urine bloody or dark colored?	_____	_____
Has it ever been in the past?	_____	_____
Do you ever lose urine when you cough/sneeze/strain?	_____	_____
Do you ever lose urine during sleep?	_____	_____
Do you notice dribbling of urine after urinating?	_____	_____
Do you have any sores or lesions on your penis?	_____	_____
Have you ever had them before?	_____	_____
Do you have any discharge from your penis?	_____	_____
Have you ever had any before?	_____	_____
Do you have any swelling or lumps on your testicles?	_____	_____
Do you have pain in your testicles?	_____	_____
Have you had or do you have prostate trouble?	_____	_____
Do you have any sexual problems or with erections?	_____	_____
.....		
Do you bruise easily?	_____	_____
Have you had any lumps on your neck, armpit or groin?	_____	_____
Do you have severe back pain?	_____	_____
Have you had back injury or surgery?	_____	_____

PAST MEDICAL HISTORY

PATIENT NAME: _____

Did you ever have any of the following illnesses? Mark Yes or No.

	Yes	No		Yes	No
Glaucoma/Cataract	_____	_____	Stomach/Duodenal ulcer	_____	_____
Other Eye problems	_____	_____	Diverticulosis/Colitis	_____	_____
Deafness	_____	_____	Gallbladder trouble	_____	_____
Bronchitis/Asthma	_____	_____	Kidney Problem/Stones	_____	_____
Emphysema	_____	_____	Bladder Problem/UTI	_____	_____
Pneumonia	_____	_____	Over Active Bladder	_____	_____
Anemia	_____	_____	Prostatitis/BPH	_____	_____
Tuberculosis	_____	_____	Convulsions/Seizures/Stroke	_____	_____
Neurologic disease	_____	_____	Arthritis disease	_____	_____
High blood pressure	_____	_____	Thyroid disease	_____	_____
Heart attack/Angina	_____	_____	Diabetes	_____	_____
Other Heart condition	_____	_____	Hepatitis/Liver	_____	_____
Heart murmur	_____	_____	Cancer or tumor	_____	_____
HIV	_____	_____	Mental illness//Depression	_____	_____
High Cholesterol	_____	_____	Bleeding tendency	_____	_____
			Sexual Transmitted Disease	_____	_____

Did you have any Weight change?.....Gain _____ Loss _____

How many cigarettes do you smoke in a day? _____/day NO _____

How many alcoholic beverages do you consume in a week _____

Do you use Marijuana or Hard Drugs?.....YES _____ NO _____

How much coffee or tea do you usually drink?.....Coffee/Tea _____ cups/day

Do you have any Sexual problems?.....YES _____ NO _____

List all previous Surgeries: _____

List all Allergies: _____

List all Medications, with doses, including aspirin and over the counter drugs _____

Which of your blood relatives have had the following diseases:
Diabetes, High blood pressure, Heart Disease, Cancer, Stones, Tuberculosis

If any parent or sibling is deceased state the cause of death:

List all previous hospitalizations and the reasons:

PHYSICIAN USE ONLY – All Other Systems Negative

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever Y N Headache Y N
 Chills Y N Other _____

Eyes

Blurred Vision Y N Double Vision Y N
 Pain Y N Other _____

Ear/Nose/Throat/Mouth

Ear infection Y N Sinus problems Y N
 Sore throat Y N Other _____

Respiratory

Wheezing Y N Shortness of breath Y N
 Frequent cough Y N Other _____

Gastrointestinal

Abdominal Pain Y N Indigestion/Heartburn Y N
 Nausea/Vomiting Y N Other _____

Genitourinary

Urine retention Y N Urinary frequency Y N
 Painful urination Y N Other _____

Musculoskeletal

Joint pain Y N Back pain Y N
 Neck pain Y N Other _____

Integumentary

Skin rash Y N Boils Y N
 Persistent itching Y N Other _____

Neurological

Tremors Y N Numbness/tingling Y N
 Dizzy spells Y N Other _____

Endocrine

Excessive thirst Y N Tired/sluggish Y N
 Too hot/cold Y N Other _____

Cardiovascular

Chest Pains Y N Varicose veins Y N
 High blood Pressure Y N Other _____

Hematologic/Lymphatic

Swollen glands Y N Blood clotting problem Y N
 Other _____

Allergic/Immunologic

Hay Fever Y N Drug allergies Y N
 Other _____

Psychologic

Are you generally satisfied with you life? Y N
 Do you feel severely depressed? Y N
 Have you considered suicide? Y N
 Other _____

Please explain any Yes answers here.

Physician use only: (Comments/Notes)

#Answer Service	Level of
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Signature: _____ Date: ____/____/____



Advanced Urology
Medical Center

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary. I understand that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: _____ **ID #** _____

Persons/organizations receiving information:

Specific description of information to release (including appointment dates and times):

I understand that I may revoke this authorization at any time by notifying the providing organization in writing.

Signature of Patient

Date

Printed name of patient's representative: _____

Relationship to the patient: _____

Notice of Privacy Practices Acknowledgement

ADVANCED UROLOGY MEDICAL CENTER

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to comply with my requested restrictions.

Patient Name _____

Patient Representative _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices" but was unable to do so, as documented below:

Date:	Initials:	Reason: