



ADVANCED UROLOGY
INSTITUTE

ADMINISTRATIVE OFFICES
12109 COUNTY RD. 103
OXFORD, FL 34484
352-391-6000

Florida Care Centers

Blountstown
Carrabelle
Daytona Beach
DeLand
Homosassa
Inverness
Leesburg
Marianna
New Smyrna Beach
Ocala
Orange City
Oxford
Palm Coast
Panama City
Perry
Port Orange
St. Augustine
Tallahassee

Let us take this opportunity to welcome you as a new patient to our practice.

We are enclosing patient history and information forms for you to complete. Some of these questions may seem unrelated to your problem. However, your cooperation in completing the history form will help us in diagnosing and treating your illness, as well as understanding the relation to other problems you may have had. Please answer ALL questions and bring these completed forms with you when you come in for your appointment.

It is important to bring your insurance card on the day of your appointment.

We accept Medicare assignment; however, you are responsible for any deductible and the 20% difference between Medicare allowable and the Medicare payment. Payment of your portion is expected at the time services are rendered. If your insurance plan requires a co-pay, please be prepared to pay it at the time services are rendered.

If you are unable to keep your scheduled appointment, for any reason, please call us immediately so we may give this time to someone else.

PLEASE BRING A LIST OF YOUR CURRENT MEDICATIONS WITH YOU.

Thank you,

The Physicians and Staff
Advanced Urology Institute

Advanced Urology, Daytona
545 Health Blvd
Daytona Beach, FL 32114

Advanced Urology, Port Orange
900 N. Swallow Tail Dr. #106
Port Orange, FL 32127

SOCIAL HISTORY:

Major Occupation (current or previous) _____

Are you retired YES NO

Are you disabled YES NO

Do you smoke YES NO

 If yes, how many packs per day _____ How many years _____

 If quit, how many years ago? _____

Do you drink alcoholic beverages YES NO

 If yes, how much _____

 If quit how many years ago _____

Do you drink caffeinated beverages YES NO

 If yes, how many per day _____

Do you use recreational drugs YES NO

Have you ever had a blood transfusion YES NO

FAMILY HISTORY:

 Kidney stones YES NO

 Prostate cancer YES NO

 Heart disease YES NO

 Diabetes YES NO

 Other: _____

REVIEW OF SYMPTOMS: Do you have any of the following symptoms? Please circle any symptoms that you have

- | | | |
|----------------------------|--------------------------|--------------------------|
| Fever | Chills | Cataracts |
| Blurry vision | Glaucoma | Sore throat |
| Hearing loss | Sinus problem/congestion | Swollen ankles |
| Chest Pains | Irregular heartbeats | Cough |
| Shortness of breath | Wheezing | O2 use |
| Abdominal pain | Nausea/vomiting | Diarrhea |
| Hematuria (blood in urine) | Decreased libido | Constipation |
| Erectile dysfunction | Joint pain | Urinary leakage |
| Chronic back pain | History of skin cancer | Walk with cane or walker |
| Rashes | Tingling | Current skin lesions |
| Numbness | Panic attacks | Dizziness |
| Depression | Weight loss | Headaches |
| | | Poor memory |

Did you receive the flu shot this year? YES NO

Have you had the pneumonia vaccine
within the last 10 years?

YES

NO

Approximate date: _____

Have you had a colonoscopy
within the last 10 years?

YES

NO

Approximate date: _____