Urology Health Questionnaire

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

What medical problems do you have? (List any medical issues **previously** or **currently** treated by a physician)

_____

Do you have or have you ever had:

High Blood Pressure	□ Yes □ No	Diabetes	□ Yes □ No
Cardiac Disease	□ Yes □ No	Chest Pain	□ Yes □ No
Heart Attack	□ Yes □ No	Stroke	□ Yes □ No
Lung/Pulmonary Disease	□ Yes □ No	Liver Disease	□ Yes □ No
Abnormal Bleeding	□ Yes □ No	Cancer	□ Yes □ No
Glaucoma	□ Yes □ No	If yes, list what type of cancer: _____	

Please list when the last time you had (Year):

Flu shot: _____ Pneumonia Vacc. (Ages 65+): _____ Colonoscopy (Ages 50-75): _____

SURGICAL HISTORY

Please list ALL surgeries you have ever had and the year of the surgery:

_____

_____

_____

Female patients: Number of pregnancies: _____ Number of Vaginal Deliveries: _____

SOCIAL HISTORY

Do you smoke?	□ Yes □ No	If so, packs per day: _____
Did you ever smoke?	□ Yes □ No	If so, number of years: _____ Packs per day: _____ Year quit: _____
Do you drink alcohol?	□ Yes □ No	If so, how many drinks per day: _____ Per week: _____

FAMILY HISTORY

If there is any family history of: (**PLEASE NOTE**: This only applies to immediate family. i.e. mother, father, sister, brother)

Kidney Stones	□ Yes □ No	If so, who: _____
Kidney Cancer	□ Yes □ No	If so, who: _____
Abnormal Bleeding	□ Yes □ No	If so, who: _____
Heart Disease	□ Yes □ No	If so, who: _____
Prostate Cancer	□ Yes □ No	If so, who: _____
Bladder Cancer	□ Yes □ No	If so, who: _____
Diabetes	□ Yes □ No	If so, who: _____
Stroke	□ Yes □ No	If so, who: _____

KIAVASH NIKKHOU, M.D.

415 Rolling Oaks Dr. Suite #260
Thousand Oaks, CA 91361
(805) 309-2555

PATIENT INFORMATION

PLEASE PRINT

PATIENT	Mr. Mrs. Miss/Mrs. Last	First	MI	Home Phone:
Patient's Home Address		City	State	Zip
Patient Email Address		Cell Phone:		
Social Security #:	Date of Birth	Age	Sex	Driver's License #:
Patient's Employer	Work Address			Work Phone:
Spouse's Name	Spouse's Employer (Name & Address)			Work Phone:
Emergency Contact: (Local/Relative/Friend)	Name	Address		Phone:

REFERRED TO THIS OFFICE BY: _____

WHO IS YOUR PRIMARY PHYSICIAN? _____

INSURANCE	PLEASE LIST ALL HEALTH CARE INSURANCE COMPANIES WHICH COVER THIS PATIENT:	
PRIMARY:	Name of Subscriber if other than yourself:	
Subscriber Date of Birth:	Subscriber Relationship to patient:	
SECONDARY:	Name of Subscriber if other than yourself:	
Subscriber Date of Birth:	Subscriber Relationship to patient:	

RESPONSIBLE PARTY	Mr. Mrs. Miss/Mrs. Last	First	D.O.B.
Address		Phone	
Occupation	Employers Name & Address	Bus. Phone:	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____

CANCELLATION POLICY: The office policy for patients who miss their appointments without calling at least 24 hours prior to their appointment to cancel is a charge of $50.00.

PLEASE READ & SIGN THE FOLLOWING:
I directly assign all medical / surgical benefits to ***Kiavash Nikkhou, M.D.,*** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ DATE _____

Review of Systems

Patient Name: _____

Date of birth: _____

General: Height: _____ Weight: _____

General good health: □ Yes □ No

Recent weight loss: □ Yes □ No

Head-Eyes-Ears-Nose-Throat:

Dizziness □ Yes □ No

Fainting □ Yes □ No

Glaucoma □ Yes □ No

Hearing impairment □ Yes □ No

Gastrointestinal:

Nausea or vomiting □ Yes □ No

Frequent diarrhea □ Yes □ No

Constipation □ Yes □ No

Liver disease □ Yes □ No

Genitourinary:

Loss of urine/incontinence □ Yes □ No

Frequent urination □ Yes □ No

Burning w/ urination □ Yes □ No

Blood in urine □ Yes □ No

Kidney stones □ Yes □ No

Sexual problems □ Yes □ No

Endocrine:

Thyroid disease □ Yes □ No

Diabetes □ Yes □ No

Cardiovascular:

Heart disease □ Yes □ No

Chest pain □ Yes □ No

Respiratory:

Pulmonary disease □ Yes □ No

Shortness of breath □ Yes □ No

Asthma/wheezing □ Yes □ No

Musculoskeletal:

Chronic back problems □ Yes □ No

Difficulty walking □ Yes □ No

Muscle weakness □ Yes □ No

Neurological-Psychiatric:

Seizures □ Yes □ No

Paralysis □ Yes □ No

Strokes □ Yes □ No

Psychiatric care □ Yes □ No

Hematologic:

Slow to heal □ Yes □ No

Bleeding or bruising tendencies □ Yes □ No

Blood transfusions □ Yes □ No

Anemia □ Yes □ No

Deep venous thrombosis □ Yes □ No

Kiavash Nikkhou, M.D., Inc.
415 Rolling Oaks Drive, Suite 260 • Thousand Oaks, CA 91361
PHONE (805) 309-2555 | FAX (805) 371-4713

Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- How this office will use and disclose your protected health information
- Your privacy rights with regard to your protected health information
- This office's obligations concerning the use and disclosure of your protected health information

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

_____ _____

Signature of Patient or Patient Representative Date

_____

Printed Name of Patient or Patient Representative

Doctors McMurray, Himsl, Santangelo, and Nikkhou
HIPAA Form

Name: _____ Date of Birth: _____

Provider (Please circle one):

Dr. McMurray Dr. Himsl Dr. Santangelo Dr. Nikkhou

Release of Medical Information

My Preferable method of contact is **(PLEASE CHECK ONE)**:

- □ Home Phone: _____
  - □ You may leave a detailed message
- □ Cell Phone: _____
  - □ You may leave a detailed message
- □ Email (Patient Portal): _____
- □ Postal Mail: _____

You may discuss my medical information with (please write full names not just relationships)

_____

_____

_____ _____

Signature of Patient Date

Patient Medication List

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

Are you allergic to any medications? □ Yes □ No

If so, please list the medications and reactions: _____

_____

Please list all medications you are taking (Prescriptions, Over the counter, Vitamins, and Supplements):

Name:	Dose:	How Often:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any type of blood thinners? □ Yes □ No Do you take Aspirin? □ Yes □ No

Pharmacy:

Local Pharmacy (please list cross streets if known): _____

Mail Order Pharmacy: _____

Laboratory:

If lab work is sent, would you like it to be sent to a specific lab? □ Yes □ No

If so, please specify: _____