GULFSTREAM
UROLOGY
ASSOCIATES, P.A.

Adam J. Ball, MD, FACS, Diplomate of the American Board of Urology

Chief Complaint (purpose of today's visit):_____

Since your last visit, have you had any NEW problems with...

Your heart/heart attack, blood pressure, or angina?	_____yes _____no
Your stomach/ulcers or colon?	_____yes _____no
Pains or difficulty with you arms or legs?	_____yes _____no
Headache, dizzy spells or fainting, or stroke?	_____yes _____no
Diabetes or control of your blood sugar?	_____yes _____no
Lungs/breathing or asthma/COPD?	_____yes _____no
Bleeding disorders or easy bruising?	_____yes _____no
Glaucoma or cataract issues/surgery?	_____yes _____no

Please provide a list of medications on the next page if you have any.

Any surgeries or procedures since your last visit?	_____yes _____no
If yes, _____	
Any changes in drinking or smoking habits?	_____yes _____no
If yes, _____	

SINCE YOUR LAST VISIT, HAVE YOU NOTICED...

Any changes in your ability to urinate?	_____yes _____no
Any burning while urinating?	_____yes _____no
Any blood in your urine?	_____yes _____no
Any difficulty starting or stopping your stream?	_____yes _____no
Any severe urgency to urinate?	_____yes _____no
Any difficulty with sexual activity?	_____yes _____no
Any difficulty with control of your urine/incontinence?	_____yes _____no

THANK YOU FOR UPDATING YOUR MEDICAL RECORD. PLEASE SIGN BELOW.

NAME/SIGNATURE:_____ **Date:**_____

Office: (772) 465-2020 • Fax: (772) 465-2111
579 NW Lake Whitney Place, Suite 105 • Port St. Lucie, Fl 34986

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Medication list

Medication	Dosage	Frequency

Patient name & DOB: _____

Pharmacy name and location: _____

_____

_____

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Authorization for Treatment

I hereby authorize **Dr. Adam J. Ball**, or a physician designated by him, or whomever he may designate as assistant to render medical care to me. I consent to care and treatment that may encompass laboratory, diagnostic, or medical treatment that my physician or his assistant may deem necessary for my health and well being.

Signature of Patient

_____

Date _____

Signature of Parent/Guardian

_____

Date _____

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I, _____ , have reviewed and agree that my insurance coverage on file is current and correct. If, for whatever reason, the information provided is incorrect, I must update Gulfstream Urology Associates, PA. If I review my insurance information at the time of service and it is incorrect, yet I fail to provide updated insurance coverage, then I am responsible for any and all of the charges occurred on that date of service.

My current primary insurance on file for Dr. Ball is:

_____

If secondary insurance listed:

_____

Patient's Signature:

_____

Date:

_____

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FLU VACCINE

Have you received a flu vaccine this season? YES NO

Approximate DATE you received vaccine: _____

If NO, please list reason: _____

_____

_____
NAME

_____ _____
SIGNATURE DATE

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