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 AN UPDATED LIST OF YOUR MEDICATIONS OR LIST BELOW.

CURRENT PHARMACY: ____________________________________

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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Patient Name: ______________________________

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: ____________

Receipt of Notice of Gulfstream Urology Associates, P.A. Payment Policy

I hereby acknowledge receipt of Gulfstream Urology Associates, P.A.'s Payment Policy. The "Notice" provides detailed information about how the practice processes your account. I understand that the practice has reserved the right to change its policies and procedures that are described in the "Notice". I also understand that a copy of any future revisions will be provided to me or made available. I understand that if I cannot keep my follow-up appointment or my procedure appointment, I need to call Gulfstream Urology Associates, P.A. twenty-four (24) hours in advance to cancel. I agree to pay **$50** (follow-up appt) or **$100** (procedure appointment) if I do not comply.

I have read and I understand the aforementioned policy. I hereby agree to each and every provision.

Signature of Patient

____

Date: ____________

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