

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: _____

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: _____