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ARIZONA UROLOGICAL SURGEONS, LLC

M. MICHAEL HAYYERI, M.D.

CONFIDENTIAL

PLEASE PRINT AND COMPLETE ALL INFORMATION IN FULL (Note: This information is only used for your protection).

Name _____Date_____
First Middle Last

Date of Birth _____-_____-_____ Gender: ❑ M or ❑ F Social Security # _____-_____-_____

Home Phone # (_____) -_____-_____ Work Phone # (_____) -_____-_____

Cell Phone # (_____) -_____-_____ E-mail Address _____

State ID / Driver's License # _____ Issuing State _____

Marital Status ❑ Married ❑ Single Name of Spouse_____

❑ Widowed ❑ Divorced No. of Children ___

Mailing Address _____
Street Number Apt # City State Zip

Patient's Employer/Name_____ Phone # (_____)-_____-_____

Primary Care/Referring Physician_____ ❑MD ❑NP Phone # (____)-_____-_____
First MI Last ❑ DO ❑PA-C

Nearest Relative_____ Relationship_____ Phone # (_____)-_____-_____
Not Living at Same Address

INSURANCE INFORMATION

Primary: _____ ID#:_____ Group #_____

Insured Name: _____ Insured's Social Security # _____-_____-_____

Insured's Employer: _____ DOB of Insured_____-_____-_____

Secondary: _____ ID#:_____ Group #_____

Insured Name: _____ Insured's Social Security # _____-_____-_____

Insured's Employer: _____ DOB of Insured_____-_____-_____

CANCELLATION POLICY: I understand when I make an appointment that the physician, provider and staff are scheduled for my care. There is a $50 charge if I miss my scheduled appointment or not cancel 24 hours in advance.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to M. Michael Hayyeri M.D. and any associates of the surgical and/or medical benefits, if any. Otherwise, it is payable to me for services rendered to me or my dependent. I also authorize my doctor to release information regarding my treatment. I understand that I am financially responsible for all charges. I will be responsible for my Medical bill if I don't give the correct insurance information at the time of service.

Do you have a living will? ❑ Y ❑ N

_____ _____
Patient Signature Date

HIPAA NOTIFICATION

I acknowledge that Arizona Urological Surgeons, LLC are in compliance with HIPAA laws regarding the Notice of Privacy Practices. This notice describes how Arizona Urological Surgeons, LLC may use and disclose my protected health information, certain restrictions on the use and disclosure of Healthcare information, and rights I may have regarding my protected health information. I understand these policies are posted within the site and a copy of these policies is available upon my request.

According to these policies, I understand that unless written permission is given patient information can only be released to the patients themselves. In compliance with these policies I hereby entitle authorization for my personal information to be discussed with the following people:

Name Relationship Phone #

_____

_____

❑ OK to leave voicemails at Home Phone # ❑ OK to leave voicemails on Cell Phone #

_____ _____ _____ _____
Signature of Patient Date Staff Initials Date

Name_____ **Date of Birth**_____

First **MI** **Last**

MEDICAL AND SURGICAL HISTORY

I. **For what medical condition are you consulting a urologic surgeon?**_____

II. **Past Medical and Surgical History**

A. Surgeries

	Hospital	Surgeon	Year
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

B. Medical Illnesses

	Yes	No		Yes	No
Heart Disease	☐	☐	High cholesterol	☐	☐
High Blood Pressure	☐	☐	Hepatitis ☐ A / ☐ B / ☐ C	☐	☐
Lung Disease (COPD) / Asthma	☐	☐	Seizure Disorder	☐	☐
Diabetes	☐	☐	Parkinson's / Alzheimer's	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐
Kidney Disease/Stone	☐	☐	Acid reflux (GERD)	☐	☐
Bowel Disease/Issues	☐	☐	Thyroid ☐ High / ☐ Low	☐	☐
Bleeding Problems	☐	☐	Depression / Anxiety	☐	☐
Sexually Transmitted Disease	☐	☐	Stroke	☐	☐
HIV	☐	☐	Other_____	☐	☐

III. **Medications (including Aspirin and Vitamin/Herbal)**

Name	Dosage	Frequency	Name	Dosage	Frequency
1.			**5.**		
2.			**6.**		
3.			**7.**		
4.			**8.**		

IV. **Allergies (to any Medications or Tapes)** ☐ **NO** ☐ **If YES, please list**

Name	Reaction	Name	Reaction
1.		**4.**	
2.		**5.**	
3.		**6.**	

V. **Family History**

	Living	Deceased	Illnesses	Age and Cause of Death
Father	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Sister(s)	#___ ☐	#___ ☐	_____	_____
Brother(s)	#___ ☐	#___ ☐	_____	_____

Name_____ **Date of Birth**_____

First **MI** **Last**

VI. Family History of the Following

	Yes	No		Yes	No		Yes	No
1. Heart Disease	☐	☐	4. Cancer(s)	☐	☐	7. Bleeding Problems	☐	☐
2. Kidney Disease	☐	☐	5. Hepatitis	☐	☐	8. Other_____	☐	☐
3. Prostate Disease	☐	☐	6. Gastrointestinal Problems	☐	☐			

VII. Social Habits

	Yes	No	
1. Do/did you smoke?	☐	☐	Amount (packs/day)_____How many years?____ When did you quit?_____
2. Do you drink alcohol?	☐	☐	
3. Any drugs (illicit)?	☐	☐	If Yes, which one(s): ☐ Coffee ☐ Tea ☐ Soda
4. Any caffeine use?	☐	☐	
5. Blood Transfusions?	☐	☐	

VIII. Do you have any of these symptoms?

	Yes	No		Yes	No		Yes	No
1. Constit.			5. Resp.			9. Neurological		
Fever	☐	☐	Cough	☐	☐	Strokes	☐	☐
Wt. Loss	☐	☐	Cough up blood	☐	☐	10. Psychiatric		
Loss of Appetite	☐	☐	Breathing difficulty	☐	☐	Memory Loss	☐	☐
2. Eyes			6. G.I.			Change in Personality	☐	☐
Vision Blurring	☐	☐	Nausea	☐	☐	11. Endocrine		
Double Vision	☐	☐	Vomiting	☐	☐	Intolerance to Heat	☐	☐
3. ENT.			Belly Pain	☐	☐	Intolerance to Cold	☐	☐
Trouble Swallowing	☐	☐	Diarrhea	☐	☐	Constant Thirst	☐	☐
Ringing in Ears	☐	☐	Blood Stool	☐	☐	12. Hematologic / Lymphatic		
4. Cardiovascular			7. Musculo-Skeletal			Lymph Node Swelling	☐	☐
Chest Pain	☐	☐	Arthritis	☐	☐	Bruise Easily	☐	☐
Shortness of Breath	☐	☐	Muscle Weakness	☐	☐			
Palpitation	☐	☐	8. Integumentary					
Swelling of Legs	☐	☐	Skin rashes	☐	☐			

IX. What is your Weight_____ Height_____

Name_____ **Date of Birth**_____
First **MI** **Last**

OFFICE USE ONLY DO NOT WRITE BELOW

X. History of Present Illness **Date of Service:** _____

PCP: _____

Other MD: _____

Last Mammo: _____

Last M. Cycle: _____

Last Colon: _____

XI. Physical Exam: Check box within Normal Limits

1. CONST. **T** **P** **BP** **RESP** **HT** **W** **BMI**_____

GEN APPEARANCE: ☐ Good Nutrition ☐ Normal ☐ Body Habits ☐ Normal Grooming

2. HEENT. **EYES:** ☐ ENT ☐ NC/AT ☐ PERRLA ☐ EOMI ☐ Glasses

3. NECK **NECK:** ☐ No Masses ☐ Symmet ☐ Trach Midline ☐ Supple

THYROID: ☐ Not Enlarged ☐ No Masses ☐ No Tenderness

4. RESP. **RESP. EFFORT** ☐ No Auscultation ☐ Normal Diaph Mvt. ☐ CTA

5. CV **AUSCULTATION** ☐ No Murms ☐ Normal Rhythm

PERIPHERAL VASCULAR ☐ No Edema ☐ No Varic. ☐ Normal Pulses

6. G.I. **ABDOMEN** ☐ No Masses ☐ BS+ ☐ NT ☐ ND ☐ No CVAT ☐ No Hernia ☐ Obese ☐ No SPT

7. EXT. ☐ No C/C/E

8. MALE G.U.

PENIS ☐ No Lesions ☐ No Masses ☐ Circ/Phimosis

URETHRAL MEATUS ☐ N1 size ☐ No D/C ☐ No Lesions

TESTES ☐ N1 size ☐ No Masses ☐ Non-Tender

EPIDIDYMIS ☐ N1 size ☐ No Masses ☐ Non-Tender

SCROTUM ☐ No Lesions ☐ No Hydro/Spermatocele/Varioceles

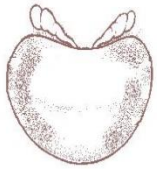
RECTAL ☐ N1 Sphincter Tone ☐ No Hemorr. (Int/Ext)

PROSTATE ☐ N1 size ☐ No Indt'n ☐ Not Boggy ☐ No Nod. ☐ NT

SEMINAL VESICAL ☐ Not Enlarged ☐ No Masses ☐ Non-Tender

Est. Prostate Volume

☐ <20 grms
☐ 20-30 grms
☐ 30-40 grms
☐ 40-50 grms
☐ >50 gms
☐ Benign



8. FEMALE G.U.

EXT GENITALIA ☐ No Lesions ☐ No Swelling ☐ N1 Hair

URETHRAL MEATUS ☐ No Lesions ☐ N1 size ☐ No Prolapse

URETHRA ☐ No Masses ☐ Non-Tender ☐ No Hypermobility
☐ Atrophic Urethiritis

BLADDER ☐ No Masses ☐ Non-Tender ☐ No Retention

VAGINA ☐ Good Support ☐ No Lesions ☐ No Discharge
☐ Good Estrogen EFF ☐ No Cysto/Recto/Entercele
☐ Atrophic Vaginitis

CX ☐ No Lesions ☐ No Disc ☐ Non-Tender

UTERUS ☐ N1 size ☐ N1Position ☐ N1 Shape ☐ Non-Tender

ADNEXA ☐ No Masses ☐ Non Tender

☐ Present for Exam

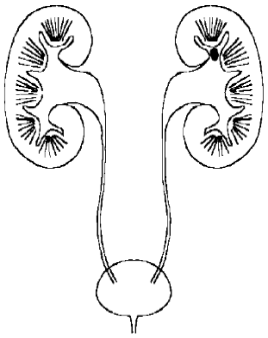
_____
Signature

Name_____ **Date of Birth**_____
First **MI** **Last**

8. **LYMPATICS** **LYMPH NODES** ☐ Neg Neck ☐ Neg Axilla ☐ Neg Groin
9. **SKIN** ☐ No rashes ☐ No Ulcers
10. **NEUROL** **ORIENT** ☐ Oriented to Time,Place and Person ☐ MOOD& AFFEC ☐ Neg Anxiety ☐ Neg Depression

RADIOLOGIC STUDIES:

Date: Type: Findings:



AUA	PSA	Urine Residual
		Catheterized _____
		Bladder U/S _____

CYSTOSCOPY:

DIAGNOSIS: 1.
2.
3.
4.

PLAN: ☐
☐
☐
☐
☐
☐

PHYSICIAN SIGNATURE: _____ **DICTATED**: ☐ **Y** ☐ **N** **TIME SPENT**: ____min____%____FTF
Marzban Michael Hayyeri, M.D.