Patient Registration Information **Date:**_____

Please PRINT and complete ALL sections below

Patient_____ **Social Security**_____
Address_____ City_____
State_____ Zip Code_____
Home Phone_____ Cell Phone_____
Age_____ Birth Date_____
Sex:____M _____F Marital Status: S M D W
Patient Employed By_____ Work Phone_____
Employer Address_____
Occupation_____

Responsible Party Information (if different from above)
Responsible Party Name_____
Social Security_____ Birth Date_____
Relationship To Patient____Spouse ____Parent ____Guardian ____Other
Address_____
Home Phone_____ Employed By_____
Work Phone_____ Occupation_____
Employer Address_____

In Case Of Emergency Notify_____
Home Phone_____ Work Phone_____
Relationship To Patient____Spouse ____Parent ____Guardian ____Other

Personal Or Referring Physician_____
Address_____
Phone_____

Please Read And Sign The Following:
I directly assign all medical/surgical benefits to Fawad S. Zafar, M.D. and understand that I am financially responsible for all charges whether or not paid by insurance. I understand that payment is due within 30 days of receiving an invoice.

I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.
Signature_____ Date_____

Lakeview Center for Urology
Dr. Fawad Zafar

Today's Date: _____ Date of Birth: _____ Age: _____

Your Full Name: _____ Gender: F_____ M_____

Full Name of Spouse/Partner (if applicable): _____

Are you employed? □ Yes □ No □ Retired If Yes, what is your occupation and company name? _____

How were you referred to us today? _____ Another Physician (Name): _____

Why are we seeing you today? _____

Have any X-Rays or any other tests done for this condition? □ Yes □ No If Yes, explain: _____

Medications:

List all medications you are presently taking:	Dosage:	Frequency (once, twice, etc, per day):

Allergies:

Have you ever had an allergic reaction to any medication? □ Yes □ No

If yes, list medications and describe reactions: _____

Have you ever had an allergic reaction to X-Ray contrast dye? □ Yes □ No

If yes, please describe: _____

Have you ever had a latex allergy? □ Yes □ No

If Yes, please describe: _____

Social History:

Tobacco use: □ Never □ Now □ In the past How much each day? _____ For how many years? _____
When did you quit? _____

Alcohol Use: □ Never □ Now □ In the past How much each day? _____ For how many years? _____
When did you quit? _____

Recreational Drug Use: □ Never □ Now □ In the past How much each day? _____ For how many years? _____
When did you quit? _____

Family History:

Please check illnesses that have occurred in any of your blood relatives:

□ Stroke	□ Cancer	□ Diabetes	□ High Blood Pressure
□ Heart Disease	□ Kidney Disease	□ Mental Illness	□ Bleeding Tendencies
□ Urinary Tract Infection	□ Kidney Stones	□ Alcoholism	□ Prostate Cancer

	Living	Present age or age at death	Significant health problems or cause of death
Father	□ Yes □ No		
Mother	□ Yes □ No		
Brothers	□ Yes □ No		
Sisters	□ Yes □ No		

Do you have any children? If so, how many? Ages? _____

Lakeview Center for Urology
Dr. Fawad Zafar

Personal Medical History:
Please check illnesses or conditions which you have had:

□ Asthma	□ Bleeding Tendencies	□ Cancer	□ Diabetes
□ Glaucoma	□ HIV	□ Heart Trouble	□ Hepatitis
□ High Blood Pressure	□ Jaundice	□ Kidney Disease	□ Nervous Disorder
□ Pneumonia	□ Arthritis/Gout	□ Stroke/TIA	□ Tuberculosis
□ Hypothyroidism	□ Sleep Apnea	□ Obesity	□ Elevated Cholesterol
□ Blood Clots	□ Heart Murmur	□ Reflux/Peptic Ulcer Disease	□ Depression

□ Other: _____

Previous Surgeries (Please list with year)
1. _____
2. _____
3. _____

Previous Hospitalizations (Please list with year):
1. _____
2. _____
3. _____

Review of Systems:
(Do you now have or have you ever had....)

Significant weight change □ Yes □ No Increased/Decreased (Circle) By how many pounds? _____

Any eye disease, injury, impaired sight?	□ Yes	□ No	Convulsions	□ Yes	□ No
Any ear disease, injury, impaired hearing?	□ Yes	□ No	Pain radiating down arm	□ Yes	□ No
Any trouble with nose, sinuses, mouth, throat	□ Yes	□ No	Shortness of breath	□ Yes	□ No
Bleeding Gums	□ Yes	□ No	Burning pain on urination	□ Yes	□ No
Trouble swallowing	□ Yes	□ No	Loss of bladder control	□ Yes	□ No
Chest pain or tightness in the chest	□ Yes	□ No	Blood in urine	□ Yes	□ No
Coughing up blood	□ Yes	□ No	Frequent urination	□ Yes	□ No
Night sweats	□ Yes	□ No	Trouble with erections	□ Yes	□ No
Palpitations	□ Yes	□ No	Painful intercourse	□ Yes	□ No
Swelling of hands or feet	□ Yes	□ No	Breast lumps	□ Yes	□ No
Weakness in arm or leg	□ Yes	□ No	Frequent or severe headaches	□ Yes	□ No
Varicose veins	□ Yes	□ No	Paralysis	□ Yes	□ No
Stomach trouble or ulcer	□ Yes	□ No	Enlarged glands	□ Yes	□ No
Constipation or diarrhea	□ Yes	□ No	Enlarged thyroid or goiter	□ Yes	□ No
Hemorrhoids or rectal bleeding	□ Yes	□ No	Pain in joints or gout	□ Yes	□ No
Fainting spells	□ Yes	□ No	Skin irritation or rashes	□ Yes	□ No
Loss of consciousness	□ Yes	□ No	Depression or anxiety	□ Yes	□ No
Spells of dizziness	□ Yes	□ No	Hallucinations	□ Yes	□ No

Form completed by: _____ Date: _____

For Office Use Only:

This section to be completed by the physician or nurse:

Hesitancy: _____
Stream: Strong: _____ Weak: _____
Urge Incontinence: _____
Stress Incontinence: _____
Nocuria: _____
ED: _____

Post Urination Dribbling: _____
Feeling of incomplete emptying: _____
Hematuria: Micro: _____ Macro: _____
Dsyuria: _____
UTI: _____
PSA: _____