THOMAS UROLOGY CLINIC
PATIENT REGISTRATION

Patient Name: (Last)_____(First) _____ Middle Initial_____

Address: _____ City, State, Zip: _____

Marital Status: Single Married Widowed Divorced

DOB: _____/_____/_____ SSN: _____ ☐ Male ☐ Female

Primary Phone: _____ Alt Phone:_____

Email(Used for invitation to Patient Portal & notification of appointments): _____

Primary Doctor: _____ Referring Doctor: _____

RESPONSIBLE PARTY(If patient is not responsible for bill payment, please indicate who is responsible)

Name: (Last) _____ (First) _____ (MI) _____ DOB: _____

Phone: (__)_____ Address: _____

City, State, Zip: _____ Relationship to Patient: _____

PRIMARY INSURANCE: _____ ID: _____

Policy Holder Name: (Last) _____ (First) _____ (MI) _____

DOB: _____ Relationship to Patient _____

SECONDARY INSURANCE _____ ID: _____

Policy Holder Name: (Last) _____ (First) _____ (MI) _____

DOB: _____ Relationship to Patient _____

EMERGENCY CONTACT

Name: (Last) _____ (First) _____

Phone: _____Relationship to Patient: _____

PREFERRED PHARMACY: _____Address: _____

AUTHORIZATION FOR PERSONS TO WHOM MY MEDICAL INFORMATION MAY BE DISCLOSED:

_____	_____	_____
Person's Name/Organization	Relationship to Patient	Contact info
_____	_____	_____
Person's Name/Organization	Relationship to Patient	Contact info

Patient signature:_____ **Date:**_____

THOMAS UROLOGY CLINIC

KENNETH R. THOMAS, MD
MICHELLE BEASLEY, FNP-C
109 DOCTORS PARK
STARKVILLE, MS 39759
PHONE: 662.498.1400
FAX: 662.498.1407

CONSENT TO TREAT

I hereby authorize Kenneth Thomas, MD to administer treatment and medications as may be deemed medically necessary and advisable.

AUTHORIZE TO RELEASE INFORMATION & ASSIGNEMENT OF BENEFITS

I hereby authorize Kenneth Thomas, MD or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare), Insurance companies or third parties, any information needed to determine these benefits payable for the related services.

I request that authorized Medicare or Insurance payments of medical benefits be made to Kenneth Thomas, MD.

FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Kenneth Thomas, MD, Thomas Urology Clinic and if this assignment is rejected, modified or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. I also understand and agree that all deductibles, coinsurance, non-covered charges and other items not paid by insurance, health plan or other third party payers are due and payable at time of service. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel and court.

This authorization and assignment may be revoked by me at any time by written notice.
I agree that a photocopy of this form may be used in lieu of the original.

CLINIC PROVIDER POLICY

Thomas Urology Clinic has multiple providers on staff, including Nurse Practitioners. Due to patient volume, we cannot guarantee that you will be seen by any particular provider. Our providers collaborate to give you the best possible care. By signing below, you acknowledge this clinic policy.

RECIEPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of Thomas Urology Clinic's Notice of Privacy Practices.

_____
Patient Signature

_____ _____
Patient Name (printed) Date

THOMAS UROLOGY CLINIC

Dr. Kenneth Thomas
Michelle Beasley, FNP-C
109 Doctors Park
Starkville, MS 39759

FEMALE MEDICAL HISTORY FORM

Name: _____ DOB: _____

Family Physician or Referring Physician: _____

This questionnaire is very important! These questions are designed to aid your doctor in assessing your problem, so please try to answer each question concisely and accurately. All information in this report and in this office is kept in the strictest confidence.

CHIEF COMPLAINT: What is the main reason for your visit today? Be precise.

_____

_____

Do you have **Urinary Symptoms**? If so, please fill out this section. If not, skip to the next section.

	Yes	No
1.) Burning on urination:	☐	☐
2.) Urinating frequent, small amounts	☐	☐
3.) Feeling like you need to urinate urgently "or else…"	☐	☐
4.) Lower abdominal "pressure"	☐	☐
5.) Do you awaken at night to urinate? If YES, how many times? _____	☐	☐
6.) Pass air or "gas" in urine	☐	☐

Do you think you may have a **Urinary tract infection**? If so, please fill out this section. If not, skip to the next section.

	Yes	No
1.) Have you ever had any previous urinary infections (cystitis)? (if none, go to next section) a.) How many? _____ b.) Last infection _____ c.) At what age did they start? _____ Related to sexual activity? _____	☐	☐
2.) Did you ever have a fever >101.5 with a urinary tract infection?	☐	☐
3.) Did you ever have pain in the flank or kidneys with a urinary tract infection?	☐	☐
4.) Have you ever had x-rays of the kidneys (IVP) or bladder (voiding cystogram)?	☐	☐
5.) Were you ever hospitalized to treat urinary infection?	☐	☐
6.) Have you ever had a sexually transmitted disease? (Circle- gonorrhea, chlamydia, herpes, genital warts, PID, other _____)	☐	☐

Do you have **Incontinence** that affects your quality of life? If so, please fill out this section. If not, skip to the next section.

	Yes	No
1.) Do you have leakage of urine (wetting of the pants) with:		
a.) Sneezing, coughing, straining	☐	☐
b.) Laughing, walking	☐	☐
c.) Upon arising from a sitting position	☐	☐
d.) Sudden urge to urinate/ cannot hold it until you get to the bathroom	☐	☐
e.) During sexual intercourse	☐	☐
2.) Do you use any pads for protection? How many per day? _____	☐	☐
3.) Do you have to push or strain to empty the bladder?	☐	☐
4.) Have you ever had a bladder suspension surgery?	☐	☐

Do you think you have or have you ever had a **Kidney Stone**? If so, please fill out this section. If not, skip to the next section.

	Yes	No
1.) Do you have pain in the flank or kidney area? If YES, Left _____ or Right _____	☐	☐
2.) Have you ever had a kidney stone? If not, go to the next section.	☐	☐
If YES a.) When? _____ b.) How many? _____ c.) Passed spontaneously? _____ d.) Removed surgically? _____ e.) Lithotripsy (shock waves)? _____		
What was stone made of? Calcium? _____ Uric acid? _____ Other? _____		
Was a metabolic evaluation done to determine the cause of the stone?	☐	☐
Were you placed on stone prevention therapy? What? _____	☐	☐

Are you here for **blood in your urine**? If so, please fill out this section. If not, skip to the next section.

	Yes	No
1.) Have you seen blood in you urine? (If no, go to question #3.)		
If YES a.) Was the blood only at the beginning of the stream?	☐	☐
b.) Throughout the stream?	☐	☐
c.) At the end of the stream?	☐	☐
Was the bloody urine (check all that apply)		
a.) Tea colored	☐	☐
b.) Rose wine/ cranberry colored	☐	☐
c.) Burgundy wine colored	☐	☐
d.) Clots	☐	☐
2.) Was there any pain or burning with the bloody urine?	☐	☐

3.) Has a doctor found blood in your urine under a microscope?	☐	☐

Review of Systems: (Please CHECK all the following symptoms you have recently had)

- ☐ Fever
- ☐ Chills
- ☐ Unintentional Weight Loss
- ☐ Sleeping Problems
- ☐ Fatigue
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Bloating
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Loss of Appetite
- ☐ Excessive thirst
- ☐ Excessive Sweating
- ☐ Increased/decreased energy level

Please list ANY other symptoms you currently have that are not listed above_____
_____
_____

Are you taking **ANY** medications now? (This includes Prescriptions, over the counter, and herbal medications.)
☐ Yes ☐ No
If yes, please list below:

Name of Medication	Dosage	How Often

Are you allergic to **ANY** medications? ☐ Yes ☐ No

Name of Medication	Type of Reaction

Social History

Do you use any tobacco products of any kind? ☐ Yes ☐ No
Approximately how much? _____
Do you consume alcohol? ☐ Yes ☐ No
How much? _____

Medical History

Have you ever been diagnosed with the following problems?

Cancer: □ Yes □ No If yes, what kind?_____

Liver Disease	□ Yes □ No	Emphysema	□ Yes □ No
Asthma	□ Yes □ No	HIV	□ Yes □ No
Kidney Disease	□ Yes □ No	Seizures	□ Yes □ No
Anemia	□ Yes □ No	Reflux	□ Yes □ No
Stroke	□ Yes □ No	Ulcerative Colitis	□ Yes □ No
COPD	□ Yes □ No	Heart Attack	□ Yes □ No
Sleep Apnea	□ Yes □ No	Anxiety	□ Yes □ No
High Cholesterol	□ Yes □ No	Diabetes	□ Yes □ No
High Blood Pressure	□ Yes □ No	Hyperthyroidism (High)	□ Yes □ No
Heart Disease	□ Yes □ No	Congestive Heart Failure	□ Yes □ No
Blood Clots	□ Yes □ No	Depression	□ Yes □ No
Arthritis	□ Yes □ No	Hepatitis	□ Yes □ No
Lupus	□ Yes □ No	Fibromyalgia	□ Yes □ No
Any Other Autoimmune Dz	□ Yes □ No	Interstitial Cystitis	□ Yes □ No

Other conditions not listed? _____

Please list all surgeries and include dates (approximate):

Procedure/Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Please list any disease that run in your family such as cancer, kidney stones, diabetes, etc.

DISEASE	FAMILY MEMBER
_____	_____
_____	_____
_____	_____
_____	_____

GYN History

Last menstrual cycle (estimate year if unknown):_____

Date of last Pap Smear: _____ Date of last Mammogram: _____

Date of last Bone Density: _____

Do ***you*** have a history of (circle all that apply): breast cancer uterine cancer ovarian cancer

Have ***you*** had:

( ) Hysterectomy with removal of ovaries

( ) Hysterectomy (removal of uterus only)

( ) Oophorectomy (removal of ovaries only)

( ) Other: _____

Birth Control Method:

( ) Menopause

( ) Hysterectomy

( ) Tubal ligation

( ) Birth control pills

( ) Vasectomy

( ) Other: _____

Have you ever had any of the following (circle all that apply):

fibrocystic breast disease leiomyoma endometrial polyps PCOS

Are you currently pregnant? ( ) Yes ( ) No

Are you currently trying to or thinking about getting pregnant? ( ) Yes ( ) No

COMPLETE HEALTH Checklist For Women

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraines/Severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair is falling out				
Cold all the time				
Swelling all over the body				
Joint pain				
Family History	**Never**	**Mild**	**Moderate**	**Severe**
Heart disease				
Diabetes				
Osteoporosis				
Alzheimer's disease				
Breast cancer				