



# COMPREHENSIVE

## UROLOGIC CARE

**PATIENT INFORMATION** (Please Print)

Date: \_\_\_\_\_

Patient First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_

Secondary Phone: (\_\_\_\_) \_\_\_\_\_

**By supplying your email address, you can gain access to your CUC online Medical Chart.**

Email : \_\_\_\_\_ ( Please avoid using Work Email Address)

\_\_\_\_ Do not have email

\_\_\_\_ Do not wish to share

\_\_\_\_ Male \_\_\_\_ Female Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **(Required for Online Chart Access)**

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Employer: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone :( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

**PRIMARY INSURANCE PLAN NAME:** \_\_\_\_\_

Please indicate: \_\_\_\_ PPO \_\_\_\_ HMO \_\_\_\_ Medicare \_\_\_\_ Self Insured

Insured Name on card If other than Patient: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE PLAN NAME:** \_\_\_\_\_

Please indicate: \_\_\_\_ PPO \_\_\_\_ HMO \_\_\_\_ Medicare \_\_\_\_ Self Insured

Insured Name on card If other than Patient: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Relationship to Patient: \_\_\_\_\_



**COMPREHENSIVE**  
**UROLOGIC CARE**

Patient First \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT**

I acknowledge that I have been made aware of CUC’s Notice of Privacy Practices, which is posted on their website, as well as available upon request in their office.

\_\_\_\_ I Place No Restrictions

\_\_\_\_ Restrict all of my Protected Health Information, except for the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**NOTICE OF INSURANCE RELEASE OF INFORMATION AND AUTHORIZATION FOR PAYMENT**

- I authorize the release of any medical or other information acquired in the course of my examination or treatment to insurance carriers.
- I authorize payment of medical benefits direct to Comprehensive Urologic Care for medical/surgical services rendered to me or my dependents.
- I understand that it is my responsibility to satisfy any payment obligations required by my insurance carrier at the time of service and am financially responsible for any services not covered by my insurance carrier.

**ACKNOWLEDGEMENT OF OFFICE POLICIES**

I acknowledge that I have been made aware of CUC’s Office Policies, which is posted on their website, as well as available upon request in their office.

**Signature of Patient or Legal Guardian**

X \_\_\_\_\_ Date: \_\_\_\_\_



## Patient Portal FAQ

### What is the Patient Portal?

Our patient portal is a safe, secure website that allows patients to access certain parts of their medical records, appointment reminders, review demographic information, prescriptions and pharmacy information for accuracy.

### What are the benefits to our patients?

You have quick, easy access to important parts of your medical chart. You can see, print and download this information at your convenience, without having to call the office.

### Is the Patient Portal safe?

Absolutely. We've invested in a secure server and a secure web domain (denoted by the "s" in the https:// portion of our Patient Portal's URL) to ensure the safety and confidentiality of your medical records.

### How do I sign up?

Just make sure we have your email address on file. After each visit, or any time a new document is added to your chart, you will receive an email notification. Just click the link that will take you to our Portal Homepage and you can sign in there.

### I'm a first time user, how do I log on?

On the homepage, on the right hand side about midway down, the words "New User – Sign Up Now" appear in blue. Click on it and it that will take you through a 3-Step process to create your user name and password. Your CUC Chart ID User name can be unique or you can use your email address. Be sure your password has an upper case, number and special character (we recommend using an exclamation point).

### Can I use the portal to schedule appointments?

It is not possible at this time to schedule appointments via the portal. Please call us during normal business hours at (847)382-5080 to schedule.

### What if I forget my password?

On the homepage below the login box, there appears a "Forgot Password" link . Once you verify your account information, a new password will be sent to you via email.

### What if I can't view my documents?

If you cannot open documents in the Visit Notes, Labs, or Reminders section of you chart, it is most likely because you do not have Adobe Reader installed. You can download this program for free from the internet.

### Is the portal meant to replace an office visit?

Not at all. The portal is a communication tool between you and our office.



# COMPREHENSIVE UROLOGIC CARE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M  F  Today's Date: \_\_\_\_\_

Primary Care MD: \_\_\_\_\_ Referring MD: \_\_\_\_\_

## Past Medical History (Check any illnesses and tell us when they occurred).

Check this box if unknown or none apply

Condition	Date	Condition	Date
Anemia	<input type="checkbox"/>	Heart Attack (MI)	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Hypertension (High Blood Pressure)	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>
Breast Cancer (Female)	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
COPD	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Chest Pains (Angina)	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	Paraplegia	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Quadriplegia	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	Spine Problems/Pain	<input type="checkbox"/>
Gout	<input type="checkbox"/>	Stroke/CVA	<input type="checkbox"/>
GERD	<input type="checkbox"/>		

Other Information \_\_\_\_\_

## Past Surgery (Check past surgeries and tell us when they occurred).

Check this box if unknown or none apply

Condition	Date	Condition	Date
Amputation	<input type="checkbox"/>	Kidney/Ureter Stone (Basketing)	<input type="checkbox"/>
Angioplasty	<input type="checkbox"/>	Kidney/Ureter Stone (ESWL)	<input type="checkbox"/>
Appendectomy	<input type="checkbox"/>	Nephrectomy	<input type="checkbox"/>
AV Fistula	<input type="checkbox"/>	Orthopedic Surgery	<input type="checkbox"/>
Back Surgery	<input type="checkbox"/>	Peripheral Bypass Surgery	<input type="checkbox"/>
Cardiac Bypass	<input type="checkbox"/>	Prostate Surgery (Greenlight Laser) (male)	<input type="checkbox"/>
Colon Resection	<input type="checkbox"/>	Prostate Surgery (Microwave) (male)	<input type="checkbox"/>
Gall Bladder Removal	<input type="checkbox"/>	Prostate Surgery (TUNA) (male)	<input type="checkbox"/>
Gastric Bypass	<input type="checkbox"/>	Prostate Surgery (TURP) (male)	<input type="checkbox"/>
Hernia Repair	<input type="checkbox"/>	Radiation of Prostate (male)	<input type="checkbox"/>
Hysterectomy (Female)	<input type="checkbox"/>	Radical Prostatectomy (male)	<input type="checkbox"/>
Mesh Hernia Repair	<input type="checkbox"/>	Small Bowel Resection	<input type="checkbox"/>

Other Information \_\_\_\_\_

**Past Urologic History (Check any illnesses and tell us when they occurred).**

Check this box if unknown or none apply

Condition	Date	Condition	Date
Bladder Cancer	<input type="checkbox"/>	Prostate Cancer (male)	<input type="checkbox"/>
Enlarged Prostate (BPH) (male)	<input type="checkbox"/>	Prostatitis (male)	<input type="checkbox"/>
Impotence (male)	<input type="checkbox"/>	Renal Insufficiency / Failure	<input type="checkbox"/>
Kidney Cancer	<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>
Kidney Cyst	<input type="checkbox"/>	Urinary Tract Infections (UTI)	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	Vasectomy (male)	<input type="checkbox"/>
<b>Other Information</b> _____			

**Family History: Check Box(es) for any illnesses in your immediate family.**

Check this box if unknown or none apply

Condition	Father	Mother	Brother	Sister	Family
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other Information</b> _____					

**Social History**

Do you smoke? Yes  No  How many packs/day? \_\_\_\_\_  
 Past Smoking? Yes  No   
 Do you Drink? Yes  No  How much? \_\_\_\_\_  
 Past Drinking? Yes  No  (Socially / Occasionally / Heavily / Recovering Alcoholic)  
 Living at? Home \_\_\_\_\_ Illicit drug use? Yes  No

**Other Information** \_\_\_\_\_

**Current Medications (Please list all medications and dosage).**

Check this box if unknown or none apply

Medicines	Strength	Dosage	Duration	Notes
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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**Do you currently have any problems related to the following? Check applicable box if yes.**

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**Constitutional**

- Fever
- Chills
- Fatigue
- Weight Loss

**Gastrointestinal**

- Abdominal
- Nausea/Vomiting
- Indigestion/Heartburn
- Loss of Appetite

**Neurological**

- Tremors
- Dizzy Spells
- Memory Problems
- Seizures

**Eyes**

- Blurred Vision
- Double Vision
- Glaucoma

**Endocrine**

- Excessive Thirst
- Hot/Cold Intolerance
- Hot Flashes

**Psychiatric**

- Depression
- Anxiety
- Irritable

**Ear/Nose/Throat/Mouth**

- Ear Infection
- Sore Throat
- Sinus Problems

**Integumentary**

- Skin Rash
- Boils
- Persistent Itch

**Genitourinary**

- Incontinence
- Painful Urination
- Frequent Urination

**Cardiovascular**

- Chest Pain
- Varicose Veins
- Palpitations/High BP

**Hematologic/Lymphatic**

- Abnormal Bruising
- Enlarged Lymph Nodes
- Anemia

**Reproductive (Male)**

- Erection Problems
- Ejaculation Problems
- Infertility

**Respiratory**

- Wheezing
- Frequent Cough
- Shortness of Breath

**Musculoskeletal**

- Joint Pain
- Neck/Back Pain
- Bone Pain

**Reproductive (Female)**

- Menopause
- Vaginal Deliveries  # \_\_\_\_\_
- Irregular Periods

**Notes/Other:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Known Allergies? None Known**

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> Penicillin (eg. Pen VK, Amoxicillin, Augmentin)      | <input type="checkbox"/> Latex      |
| <input type="checkbox"/> Sulfa (eg. Septra, Bactrim)                          | <input type="checkbox"/> Peanuts    |
| <input type="checkbox"/> Cephalosporins (eg. Keflex, Duricef, Ceftin, Ceclor) | <input type="checkbox"/> Shell Fish |
| <input type="checkbox"/> Macrobid (Nitrofurantoin)                            | <input type="checkbox"/> Iodine     |
| <input type="checkbox"/> Cipro  | <input type="checkbox"/> Demerol    |
| <input type="checkbox"/> Levaquin   | <input type="checkbox"/> Morphine   |
| <input type="checkbox"/> Tetracycline   | <input type="checkbox"/> Codeine    |

**Any Other:** \_\_\_\_\_