STAR UROLOGY, INC.
Kamyar Ebrahimi, M.D.

New Patient Questionnaire

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The ***Patient/Doctor*** *relationship is a privileged relationship built on trust and honesty.*
By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.
I/We hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by Dr Ebrahimi and/or Physician Assistant and/or Nurse Practitioner of STAR Urology Inc, and Dr K Ebrahimi to me, or to the below named minor of whom I am the parent or legal guardian. *I understand that I am directly responsible for all charges incurred for medical services for myself (or my dependents when applicable) regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract and valid authorization. I understand that these charges incurred due to my visits or procedures and possible office imaging with STAR Urology Inc and Dr Ebrahimi do not include any laboratory or fees charged by other clinics or hospitals performed outside of Dr Ebrahimi's office. I furthermore agree to pay legal interest, collection expenses, and attorney's fees incurred to collect any amount I may owe.*
I also hereby authorize STAR Urology Inc, and Dr K Ebrahimi to release information requested by insurance companies and /or its representatives.
BY SIGNING BELOW YOU FULLY UNDERSTAND THIS AGREEMENT AND CONSENT WILL CONTINUE UNTIL CANCELLED BY YOU IN WRITING.

_______________________________ _____________________
Signature of Patient/ or Responsible Party **Today's Date**

____
Name of Patient/Responsible Party (Please Print)

Patient Name: ____ **Gender** _M _F
Last First Middle
Date of Birth (*MM/DD/YYYY*) _____/_____/_________ **Social Security Number:** _____ - _____ - _______

Patient Contact Information:
Address: ____ Zip: ______

Home Phone ___________________ Cell Phone __________________ **e-mail**: ____________________

Emergency Phone Contact: _____________________________

Primary Insurance Name:________________________

Reason For Your Visit: ____

PHARMACY Name: ____

How did you find us?
☐Online (Google, Yahoo, Bing) and if so, what were you looking for? _______________________
☐Friend or family? _______________________
☐Your doctor? _______________________

Who is your Primary Care Doctor:
Names _____________________________ Contact #________________________FAX: ________________

List Urologist(s) you have seen in the past or currently:
Names _____________________________ Contact #________________________FAX: ________________

Other Doctors Who Take Care of you:
Names ______________________________ Contact #_________________________FAX: _________________
Names ______________________________ Contact #_________________________FAX: _________________

Allergies: ☐ IV Contrast Dye ☐ insect stings

Medication Allergies:

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

What are your CURRENT Medications (including over the counter, herbs & vitamins)**:**

Medication Name	*Dose*	*Frequency*
_____________________________	________________	___________________
_____________________________	________________	___________________
_____________________________	________________	___________________
_____________________________	________________	___________________
_____________________________	________________	___________________

Past Medical History (check all that apply):

☐Yes	☐No	Alzheimer	☐Yes	☐No	Hepatitis
☐Yes	☐No	Anxiety Disorder	☐Yes	☐No	Hypertension
☐Yes	☐No	Arthritis	☐Yes	☐No	Hyperthyroidism
☐Yes	☐No	Asthma Mania	☐Yes	☐No	Hypotension
☐Yes	☐No	Autoimmune Disease	☐Yes	☐No	Hypothyroidism
☐Yes	☐No	Bipolar Disorder	☐Yes	☐No	Hemorrhoids
☐Yes	☐No	Bleeding Disorder	☐Yes	☐No	Irregular Heart Rhythm
☐Yes	☐No	Dialysis	☐Yes	☐No	Liver Dysfunction
☐Yes	☐No	Cerebrovascular Accident (Stroke)	☐Yes	☐No	Muscular Dystrophy
☐Yes	☐No	Chemotherapy	☐Yes	☐No	Heart Attack
☐Yes	☐No	Claudication	☐Yes	☐No	Heart Disease
☐Yes	☐No	Clotting Disorder	☐Yes	☐No	Heart or Valve Defects
☐Yes	☐No	Congenital Heart Defects	☐Yes	☐No	HIV or AIDS
☐Yes	☐No	COPD	☐Yes	☐No	High cholesterol / Dyslipidemia
☐Yes	☐No	Coronary Artery Disease	☐Yes	☐No	Diabetes
☐Yes	☐No	Seizure Disorder	☐Yes	☐No	Depression

Add any diseases not listed:
____ ____

Past surgical history:
☐Appendectomy ☐Back Surgery ☐Breast Surgery ☐Caratacts ☐Cholecystectomy ☐Circumcision
☐C-Section ☐Foot And Ankle ☐Heart Surgery ☐Nose Surgery ☐Knee Surgery ☐Oral Surgery
☐Tonsillectomy ☐Vasectomy **☐NONE**
☐ Kidney stone surgery ___________________________
☐ Prostate surgery ____________________________________
☐ Bladder surgery ____________________________________

Social History:
Do you exercise? ☐Yes ☐No. If yes, please describe: ____
Tobacco use? ☐Yes ☐No If yes, ______ # packs per day for ____ years. Quit:_____
Alcohol use? ☐Yes ☐No. If yes, specify _______ # drinks per week
Illicit drug use? ☐No, if yes: ☐Amphetamines ☐Cocaine ☐Marijuana ☐Heroin ☐Inhalants ☐LSD
Marital status: ☐Single ☐Married ☐Divorced ☐Widowed
Occupation: ______________________ Retired? ☐Yes ☐No

Family Medical History (please list major medical problems such as diabetes, heart attacks, strokes, cancers)

____

____

☐Prostate Cancer ________________________ ☐Kidney Cancer ________________________

☐Kidney Stones ___________________________ ☐Other Cancers ____________________

Review of Systems:

		Constitutional			Heme/Lymph
☐Yes	☐No	Appetite changes	☐Yes	☐No	Bleeding from gums or nose
☐Yes	☐No	Fatigue	☐Yes	☐No	Blood in your stool
☐Yes	☐No	Fever	☐Yes	☐No	Unexplained bruising
☐Yes	☐No	Chills	☐Yes	☐No	Night Sweats
☐Yes	☐No	Night sweats	☐Yes	☐No	Swollen, painful lymph nodes
☐Yes	☐No	Weight Loss or Gain			
					Musculoskeletal
		Cardiovascular	☐Yes	☐No	Back pain
☐Yes	☐No	Chest pain or heaviness	☐Yes	☐No	Broken bones
☐Yes	☐No	Palpitations	☐Yes	☐No	Joint pain or swelling
☐Yes	☐No	Swelling of feet or legs	☐Yes	☐No	Muscle aches
☐Yes	☐No	Shortness of breath lying flat in bed			
		Neurologic			**Respiratory**
☐Yes	☐No	Seizures	☐Yes	☐No	Chest tightness
☐Yes	☐No	Dizziness	☐Yes	☐No	Cough lasting >1 month
☐Yes	☐No	Excessive daytime sleepiness	☐Yes	☐No	choking with swallowing
☐Yes	☐No	Extremity pain or burning	☐Yes	☐No	Shortness of breath
☐Yes	☐No	Numbness or tingling	☐Yes	☐No	Wheezing
		Psych			
☐Yes	☐No	Anxiety without clear explanation			
☐Yes	☐No	Difficulty falling or staying asleep			
☐Yes	☐No	Sadness lasting for days or weeks			
☐Yes	☐No	Suicidal thoughts			

Urologic History:

☐Yes	☐No	Adrenal Dysfunction	☐Yes	☐No	Sexually Active?
☐Yes	☐No	Blood In The Urine	☐Yes	☐No	Sexually Transmitted Disease
☐Yes	☐No	Difficulty With Urination	☐Yes	☐No	Gonorrhea
☐Yes	☐No	End Stage Renal Disease	☐Yes	☐No	Herpes
☐Yes	☐No	Feeling Of Incomplete Emptying	☐Yes	☐No	HIV
☐Yes	☐No	Flank Pain? Which Side ___	☐Yes	☐No	Syphilis
☐Yes	☐No	Frequency	☐Yes	☐No	Sleep Apnea
☐Yes	☐No	Incontinence	☐Yes	☐No	Snoring
☐Yes	☐No	Kidney Failure, Or Dysfunction	☐Yes	☐No	Urgency
☐Yes	☐No	Kidney Stones	☐Yes	☐No	Urinary Retention
☐Yes	☐No	Painful Urination	☐Yes	☐No	Wake Up To Urinate At Night?

MEN

☐Yes	☐No	Decrease in force of stream	☐Yes	☐No	Prostatic pain
☐Yes	☐No	Erection problems	☐Yes	☐No	Scrotal pain
☐Yes	☐No	Prostate Biopsy			

WOMEN

☐Yes	☐No	Abnormal Pap smear	☐Yes	☐No	Number of pregnancies? ____
☐Yes	☐No	Discomfort during sex	☐Yes	☐No	Number of live births? ____
☐Yes	☐No	Menstrual changes	☐Yes	☐No	Number of miscarriages? ____
☐Yes	☐No	Vaginal discharge or bleeding	☐Yes	☐No	Number of abortions? ____
☐Yes	☐No	Vaginal pain	☐Yes	☐No	hormone replacement therapy