Northwest Suburban UROLOGISTS

900 E. Rand Rd.
Des Plaines, IL 60016
Tel: 847.823.3185

Patient Information Form - Please Print and Use Black Ink ONLY

Date___________________________ ***Patient's SSN:*** _________________________________

Patient's Name____
Last Name ***First Name*** ***Initial***

Street Address____

City____ ***State***______________________ ***Zip Code***______________

Patient's Home Phone _____________________ ***Patient's Cell Phone***_________________________________

Patient's Email Address:____

Birthdate__________________________ **M** **F** Age__________ Single Married

Patient Employed By____________________________ ***Business Address*** ____________________________________

Business Phone________________________________ ***Occupation***____

Spouse's Name__________________________________***Spouse's Phone***______________________________________

Name of Primary Insurance Co.____

Policy Holder Name ___________________________________ ***Policy ID #*** ______________________________

Policy Holder SSN _____________________________________ ***Group #***_________________________________

Copay Amount: ___________________________ ***Policy Holder DOB*** ________________________
Please note your copay must be paid prior to seeing the physician at each visit

Name of Secondary Insurance Co.____

Policy Holder Name ___________________________________ ***Policy ID #*** ______________________________

Policy Holder SSN _____________________________________ ***Group #***_________________________________

Policy Holder DOB _______________________________________

IF PATIENT IS A MINOR:
Father's Name ___________________________________ ***Mother's Name***____
Address____ ***Address***____
Phone____ ***Phone***____
DOB_________________ ***SSN***_______________________ ***DOB***_____________________ ***SSN***_______________________

Referring Physician: ____________________________________ **Primary Care Physician:**___________________________

In case of emergency, who should be notified?_________________________________ **Phone**__________________________

<u>Kindly provide 24 hours cancellation notice to avoid a $25 cancellation/no-show fee</u>

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PAST HISTORY: (circle where indicated)
Illnesses: Please circle if you have had any of these problems

Rheumatic Fever Scarlet Fever Pneumonia Jaundice Cancer Ulcers
Anemia Arthritis Emphysema Diabetes Heart Disease Stroke
High Blood Pressure Asthma Tuberculosis Seizures High Cholesterol
Bleeding Tendency Parkinson's Nervous Disorder

Please list other (non-surgical) illnesses requiring
hospitalization:____

____

____

OPERATIONS: Please circle if you have had surgery on: tonsils appendix uterus gallbladder
Other Operations? Please date and list:____

____

MEDICATION ALLERGIES: Please circle: No Medication Allergies Penicillin Sulfa Iodine Seafood
Others? ____

SPECIAL NEEDS: Please circle: Wheelchair Bound Use a walker Stretcher

IMPLANTS OR FOREIGN BODIES: Please circle: NO YES
If yes, what kind and what year? ____

SYSTEM REVIEW: Please Circle: Heart or Lung Trouble Chest Pain Shortness of Breath Smoke
Cough Neuromuscular Problems Seizures Nervous Dizzy Spells Stroke
Depression Weight Loss Present Weight: ___________ Height: _____________
GI: Constipation Blood in Stool Gastric Distress Irritable Bowel
EENT: Recent Onset of Headaches Eye Problems Glaucoma
For Women Only: # of Pregnancies:________ # of Miscarriages: _______ Vaginal Discharge: ________
Pain with Intercourse: ________ Last Menstrual Period (date or years): ____________
Other: ____

FAMILY HISTORY: How many brothers &/or Sisters? ____________ Any ill or Deceased? ________
Mother: Alive or Deceased (circle) Cause of death and Age: ____________________________
Father: Alive or deceased (circle) Cause of death and Age: ____________________________
Please circle if any blood relatives (not yourself) have had these problems:
Birth defect of kidney or Bladder Urinary Problems Cancer Diabetes
High Blood Pressure Kidney Stones Cancer of Prostate Bleeder
Other health problems? ____

SOCIAL HISTORY:
Your usual occupation: ______________________________ Retired? YES or NO
Of Sons: ______________ ages: __________ # of Daughters: ______________ ages: _____________
Spouse's health: ________________________ Spouse's occupation: _____________________________
HABITS: Please circle:
Smoke: No / Quit: Date and Year____
Yes /How many pack of cigarettes per day: ____________ How many years? _________
Alcohol: No / Yes: Heavy Moderate Light Occasionally # shots/beers per day: ___________
Recovering Alcoholic (or other drugs)? ____

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