MISSOURI DELTA
UROLOGY

Dear New Patient,

Thank you for choosing Missouri Delta Urology!

To save time during your first appointment, feel free to print and fill out the following forms and bring with you to your appointment.

☐ Patient Information ☐Health History Form ☐ Acknowledgement of Privacy Practices

Also, please remember to bring with you to the appointment:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

We look forward to meeting you. If you have any questions, please let us know!

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MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON, MISSOURI

PATIENT INFORMATION
(to be completed by patient) **Date:** _____

Name: First _____ Middle _____ Last _____

Date of Birth	Age	Sex	Marital Status	Race	Religion
_____	_____	_____	_____	_____	_____

Social Security Number	Maiden/Other Name	Family Doctor
_____	_____	_____

Patient Address _____

City/State/Zip _____ Home Phone _____ Cell Phone _____

Email Address _____

Patient Employer _____

Address: _____

City/State/Zip _____ Phone _____

Preferred Pharmacy _____

Next of Kin

Spouse/Father/Mother Name _____ D.O.B. _____

(Spouse or Parent if Patient is under 18 years of age)

S.S.N.# _____ Cell Phone Number _____

Address if different from above _____

Spouse/Parent Employer _____

Address _____

City/State/Zip _____ Phone _____

Closest Relative NOT Living With You

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Person to Notify (other than Next of Kin)

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Missouri Delta Physician Services

WELCOME TO OUR PRACTICE

Missouri Delta Urology
Animesh Sahai, MD

NAME: _____ AGE: _____

I. REASON FOR VISIT TODAY- Please mark all that apply.

☐ Yearly check-up ☐ Discharge ☐ Slow stream when urinating ☐ Incontinence
☐ Blood in urine ☐ Sores ☐ Pain/Burning with urination ☐ Frequency
☐ Impotence ☐ Sterilization ☐ Cancer Other: _____

Referring Physician: _____

PLEASE LIST ALL PHYSICIANS THAT PARTICIPATE IN YOUR CARE.

NAME	SPECIALITY
_____	_____
_____	_____
_____	_____

II. PAST HISTORY

Have you had any previous surgeries? YES NO
Please specify the year and the type of surgery. _____
_____

Pharmacy: _____
Are you on any medications? YES NO
If yes, please list name, dosage and frequency.
_____
_____
_____

Are you allergic to any medications? YES NO
If yes, please list._____
_____

Please mark all that apply.

Medical Illness: ☐ HIV ☐ Measles ☐ Venereal Disease ☐ Whooping cough ☐ Pneumonia
☐ Mumps ☐ Influenza ☐ Chickenpox ☐ Tuberculosis ☐ Tonsillitis ☐ Asthma
☐ Scarlet fever ☐ Arthritis ☐ Diphtheria ☐ Blood clots ☐ Rheumatic fever ☐ Heart problems
☐ Hepatitis A, B, or C ☐ High blood pressure ☐ Diabetes ☐ Cancer, type_____

III. FAMILY HISTORY- Please mark all that apply.

☐ Cancer, type _____ ☐ Tuberculosis ☐ Allergy ☐ Diabetes ☐ Arthritis
☐ Kidney disease ☐ Heart problems

IV. SOCIAL HISTORY

Do you smoke? YES NO If yes, how many packs per day_____ How many years? _____
Do you drink alcohol? YES NO How many drinks per day? _____
Are you married? _____ Children? YES NO How many? _____
Occupation? _____

PLEASE MARK ANY OF THE FOLLOWING THAT HAVE APPLIED

GASTROINTESTINAL	NEUROMUSCULAR	FEMALE REPRODUCTIVE
☐ Blood in stool	☐ Weakness	Irregular periods? YES NO
☐ Hemorrhoids	☐ Joint Pain	Pregnancy? YES NO
☐ Hernia	☐ Paralysis	How many? _____
☐ Ulcers	☐ Back Pain	Complications? _____
	☐ Deformities	

MISSOURI DELTA MEDICAL CENTER

SIKESTON MISSOURI

ACKNOWLEDGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: _____

Date:_____

□ Patient was unable /unwilling to sign acknowledgment.

Reason: _____

Staff initials: _____

Date: _____

Time: _____

Below is a list of people that may receive full disclosure of my medical information:

_____

_____

_____

Copy of Notice was included in patient's Admission Information Packet