

Date _____

Dear _____

Your appointment with Dr. _____ has been scheduled on _____ at _____ [] a.m. [] p.m.

In order to ensure that we have the necessary information needed for your appointment, please read the following instructions carefully.

PAPERWORK

We have enclosed the necessary paperwork needed for your office visit. Please fill it out completely and bring it back with you for your appointment. If you choose to fill it out at our office, you will need to arrive 20/30 minutes early to ensure the paperwork is completed in time for your appointment.

INSURANCE

In order to properly bill for your visit, please bring your insurance card/cards with you. We will need to copy these for billing purposes. If you have new insurance and have not received your card, you will need to bring all necessary information regarding your insurance in order to properly bill for services. **If you do not bring this information, you will be expected to pay for all charges the day of your appointment.**

PAYMENT OF SERVICES

For those with insurance, your copay will be collected when you check in for your appointment. If you **DO NOT** have insurance, we will expect payment the **day of your appointment**. We accept Visa, MasterCard, Discover, cash and checks (which will be processed electronically).

REFERRAL POLICY

A referral is needed for **Tricare Prime** and most **HMO** insurances. If you need a referral contact your Primary Care Physician and have them fax a copy to our office, **prior** to your appointment, or you may bring it with you.

CANCELLATION, NO SHOW OR LATE APPOINTMENT POLICY

We will call and confirm your appointment 24 hours in advance. If your schedule, changes, please call our office within **24** hours of your appointment to cancel. If you **do not call** to cancel, or **do not show** for your appointment, you will be billed a **\$50** administration fee for the missed appointment. In addition, if you are **late** for your appointment you may be rescheduled. If you are **more than 15 minutes late** for your appointment, **you will be rescheduled**. **We work hard to stay on schedule, however emergencies do arise at times creating unforeseen delays. We apologize for any inconvenience in the event your appointment is delayed.**

Prior to seeing the doctor, you may be asked to leave a urine specimen. Please be prepared to do so. If you feel you cannot wait until you are called, see the receptionist for instructions.

Thank you for scheduling an appointment with Urological Associates, we look forward to meeting you. If you have any questions, please contact our office between 8:00 a.m. and 4:30 p.m., Monday-Friday.

PATIENT INFORMATION
(Please print)

PATIENT

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____
City State Zip

Street Address (if different): _____
City State Zip

Home Phone: _____ Work Phone: _____ SS#: _____

Employer's Name and Address: _____

Sex: M F

INSURED'S NAME (if other than patient or if patient is a minor)

Name: _____ Date of birth: _____

Mailing address: _____
City State Zip

Home phone: _____ Work phone: _____ SS#: _____

Relationship to patient: _____ Marital status: S M D W Spouse's name: _____

Employer's name and address: _____

INSURANCE (Please take your drivers license and insurance cards to the front desk to be scanned)

Primary

Secondary

Company _____

ID No. _____

Group No. _____

THE FOLLOWING INFORMATION IS MANDATORY

Who is the patient's primary care physician? _____ Phone: _____

Name of physician who referred you here: _____ Phone: _____

Emergency contact not residing with the patient: _____ Phone: _____

I hereby authorize Urological Associates. P.C. to provide medical treatment services to me and/or my dependents. In doing so, I assign to the physicians all payments for medical services provided. I understand that I am responsible for any amount not covered by my insurance. I also understand that if I do not have insurance, I am responsible for all charges associated with my visit to be paid in full the day of my visit.

SIGNATURE

DATE

Urinary Symptom Index Questionnaire

Patient name _____ Date _____

(Circle the number that best applies to you for each question)

	Not at all	Less than 1 time in 5	Less than ½ the time	About ½ the time	More than ½ the time	Almost always
1. Over the last month or so, how often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. During the last month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. During the last month or so, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. During the last month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. During the last month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. During the last month or so, how often have you had to push to begin urination?	0	1	2	3	4	5

	None	1 time	2 times	3 times	4 times	5 or more times
7. During the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add up all number circled above and write the total in the space to the right.

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe **TOTAL** _____

Quality of Life

	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Past Medical History

Please check all that apply:

Name: _____ Date: _____

	Onset date mm/yy		Onset date mm/yy
<input type="checkbox"/> Abdominal Aortic Aneurysm	_____	<input type="checkbox"/> DVT (blood clot in legs)	_____
<input type="checkbox"/> Alcohol Withdrawal	_____	<input type="checkbox"/> Dyspareunia (painful intercourse)	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Elevated Blood Pressure Rating	_____
<input type="checkbox"/> Angina Pectoris (chest pain)	_____	<input type="checkbox"/> Elevated prostate specific antigen	_____
<input type="checkbox"/> Aortic Valve Disease	_____	<input type="checkbox"/> Emphysema	_____
<input type="checkbox"/> Aortic valve replacement	_____	<input type="checkbox"/> Esophageal Reflux (GERD)	_____
<input type="checkbox"/> Appendicitis	_____	<input type="checkbox"/> Fibromyalgia	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Frequent UTI'S	_____
<input type="checkbox"/> Backache	_____	<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Bladder Cancer	_____	<input type="checkbox"/> Head Injury	_____
<input type="checkbox"/> BPH (enlarged prostate)	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Breast Neoplasm, Malignant (cancer)	_____	<input type="checkbox"/> Heart Failure	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Hematuria (blood in urine)	_____
<input type="checkbox"/> Cardiac Dysrhythmia (irregular heartbeat)	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Carotid Stenosis	_____	<input type="checkbox"/> HIV / AIDS	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Hormone Replacement Therapy	_____
<input type="checkbox"/> Cervical Cancer	_____	<input type="checkbox"/> Incontinence (leakage)	_____
<input type="checkbox"/> Cesarean Delivery	_____	<input type="checkbox"/> Infection of Kidney	_____
<input type="checkbox"/> Cholelithiasis (gall stones)	_____	<input type="checkbox"/> Kidney stones	_____
<input type="checkbox"/> Chronic Prostatitis	_____	<input type="checkbox"/> Kidney x-ray (IVP)	_____
<input type="checkbox"/> Chronic Renal Failure	_____	<input type="checkbox"/> Mitral valve repair	_____
<input type="checkbox"/> Coagulation Defect (bruise easily)	_____	<input type="checkbox"/> Multiple Sclerosis	_____
<input type="checkbox"/> Colitis, Ulcerative	_____	<input type="checkbox"/> Myocardial Infarction (heart attack)	_____
<input type="checkbox"/> Colon Cancer	_____	<input type="checkbox"/> Neuropathy	_____
<input type="checkbox"/> Congestive Heart Failure	_____	<input type="checkbox"/> Nocturnal Enuresis (bedwetting)	_____
<input type="checkbox"/> COPD	_____	<input type="checkbox"/> Parkinson's Disease	_____
<input type="checkbox"/> Crohn's Disease	_____	<input type="checkbox"/> Peripheral Vascular Disease	_____
<input type="checkbox"/> CVA (stroke)	_____	<input type="checkbox"/> Prostate Cancer	_____
<input type="checkbox"/> Cystitis (bladder infections)	_____	<input type="checkbox"/> Senile Dementia	_____
<input type="checkbox"/> Cystocele	_____	<input type="checkbox"/> Testicular Cancer	_____
<input type="checkbox"/> Cystoscopy	_____	<input type="checkbox"/> Urethral Stricture	_____
<input type="checkbox"/> Diabetes Mellitus, Type I, IDDM (insulin dependent)	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Diabetes Mellitus, Type II	_____	<input type="checkbox"/> Other _____	_____
		<input type="checkbox"/> Other _____	_____

Turn Over to Complete

Medical History

Please complete your past medical, social, and family history:

If male, have you had a PSA blood test? **Y** **N** If yes, please list result and date: _____

Please list any surgical procedures:

Type of Surgery	Year	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all medicines and doses.

Please list allergies/reactions to medications.

Medicine	Dosage Amt	Allergy	Reaction
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____
5. _____	_____	5. _____	_____
6. _____	_____	6. _____	_____

Is there a family history of:

Bedwetting	Y	N	Who? _____	Age at onset? _____
Diabetes	Y	N	Who? _____	Age at onset? _____
Kidney failure	Y	N	Who? _____	Age at onset? _____
Kidney stones	Y	N	Who? _____	Age at onset? _____
Prostate cancer	Y	N	Who? _____	Age at onset? _____

Have you smoked tobacco products? **Y** **N**

If yes, are you a former or current user?

If former or current, how many years? _____

Do you use caffeine? **Y** **N**

If yes, how many cups per day? _____

Do you drink alcohol? **Y** **N**

If yes, describe use:

mild moderate heavy (circle one)

Travel overseas? **Y** **N** When? _____ Where? _____

Occupation _____

Retired? **Y** **N** Semi

Are your parents living? **Y** **N**

If not, ages at time of death and cause:

Mother: _____

Father: _____

Women Only Health Section

Number of children? _____

Number of pregnancies? _____

Are you on birth control? **Y** **N**

Do you have irregular periods? **Y** **N**

Do you have painful periods? **Y** **N**

Are you sexually active? **Y** **N**

Chief Complaint:

What is the main reason for your visit today, and have you ever seen a urologist? Describe your urological problem.

History of Present Illness:

When did you first notice the problem? Date: (mm/yyyy) _____

Is the problem continuous or does it come and go? _____

Does anything make your problem worse or better? Y N Which? Worse Better

Rate the severity of your problem from 1-10. _____

Review of Systems

Do you currently have any problems listed below?

Cardiovascular

Chest pain Y N

Rapid heartbeat Y N

Other _____

Constitutional Symptoms

Weight loss Y N

Fever Y N

Chills Y N

Other _____

Endocrine

Heat intolerance Y N

Cold intolerance Y N

Increased thirst Y N

Other _____

Eyes

Blurred Vision Y N

Eye pain Y N

Other _____

Gastrointestinal

Constipation Y N

Diarrhea Y N

Abdominal pain Y N

Vomiting Y N

Other _____

Genitourinary

Blood in urine Y N

Urinary frequency Y N

Burning on urination Y N

Urinary leakage Y N

Bedwetting Y N

Difficulty with intercourse Y N

Urinary urgency Y N

Other _____

Hematologic

Easily bruised Y N

Swollen lymph nodes Y N

Easy bleeding Y N

Other _____

Musculoskeletal

Joint pain Y N

Bone pain Y N

Back pain Y N

Other _____

Neurological

Tremors Y N

Loss of balance Y N

Memory loss Y N

Other _____

Respiratory

Shortness of breath Y N

Frequent cough Y N

Other _____

**UROLOGICAL ASSOCIATES, P.C.
75 PRINTERS PARKWAY, SUITE 200
COLORADO SPRINGS, CO 80910**

Consent to Use and Disclose Protected Health Information

Protected health information (PHI) will be disclosed or used by Urological Associates for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations.

I understand that I have a right to request restrictions of the uses and disclosures of my PHI for the above stated purpose. But you are not required to agree with these restrictions.

If you would like to view the Notice of Privacy Practices for more detailed information just ask the receptionist for the binder with this information in it.

I understand I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Our office may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. These messages may contain confidential information not intended for others. To avoid any breach in confidentiality, please review the choices below and check those that apply:

Yes, the doctor's office may leave messages on my answering machine/voice mail.

No, do not leave any messages. I have no answering machine.

In some cases it is helpful for a spouse or family member to be informed of you medical care, to include test results. Please mark yes or no below for what applies.

Yes, your office may discuss my medical care with the names listed below:

<u>Name</u>	<u>Phone #</u>	<u>Relationship to Patient</u>
--------------------	-----------------------	---------------------------------------

No, do not discuss my medical care with anyone other than me.

Please print name

Signature of Patient/Guardian

Date