Date ______________________

Dear ____

Your appointment with Dr. ____________________has been scheduled as follows:
Vasectomy consult: __________________at _________________. Please arrive 15 minutes prior to watch a video before seeing the physician.
Vasectomy procedure: __________________at ______________________.

Our office is located at 75 Printers Parkway, Ste 200, Colorado Springs, CO.

In order to ensure we meet with you on time, please have the enclosed paperwork completed and bring it with you to your appointment, along with your insurance card. If you do not have insurance, we honor Visa, MasterCard, electronic checks and cash.

We are contracted with many insurance plans, however, in order to ensure our physician is listed on your insurance plan, please call your insurance company. **If you are covered by an HMO Plan, please contact your primary care physician to request that a referral be forwarded to our office, prior to your visit. If we do not receive a referral, your appointment may be rescheduled. Please be prepared to pay your co-payment or co-insurance at the time or your visit.**

We will call you prior to your visit to confirm the date and time of your appointment. If your schedule changes, please call our office to cancel your appointment. **If you do not give 24 hours notice of a cancellation, you will be billed $100.00.**

We are looking forward to meeting you. If you have any questions, please feel free to contact our office. Our hours are Monday-Friday from 9:00 am-Noon and 1:30 until 4:30pm.

Sincerely,

The Staff of Urological Associates, P.C.

A NOTE TO OUR VASECTOMY PATIENTS

We are pleased you have chosen a physician at Urological Associates to perform your vasectomy. This letter is intended to provide you with additional information that many of our patients have found helpful.

We request that prior to coming to the office for the vasectomy that you shave the entire scrotum, (the area above the penis does not need to be shaved.) Please shower afterward to remove any loose hair. There is no need to fast prior to the procedure, although it is necessary to abstain from alcohol for 6 hours prior to the vasectomy.

The procedure is done using a local anesthetic, and mild sedation is often used. If you would like to have the sedation, please plan on having someone drive you home. It is a good idea to wear a snug pair of briefs or an athletic supporter to the procedure and to continue the use of the support until all swelling has resolved.

The office is working on making changes in our scheduling procedures so that the waiting period between the consultation and the vasectomy appointments can be shortened. Unfortunately, last minute cancellations continue to be a significant problem. We understand that circumstances can occur which necessitates canceling an appointment. We also understand that patients change their minds; however if a cancellation occurs less than 48 hours of the scheduled vasectomy, a fee of $100 will be charged. We appreciate your help with this aspect of our scheduling.

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.	______________________________	______________________________

<u>THE FOLLOWING INFORMATION IS MANDATORY</u>

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

	Medicine	Dosage Amt
1.		
2.		
3.		
4.		
5.		
6.		

Please list allergies/reactions to medications.

	Allergy	Reaction
1.		
2.		
3.		
4.		
5.		
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___________________________

*****Turn Over to Complete*****

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:

Name	Phone #	Relationship to Patient

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

____

Please print name Signature of Patient/Guardian Date