

How did you find out about our services?

F

- Another Person ... Who? \_\_\_\_\_
- Another Doctor ... Who? \_\_\_\_\_
- Other ... How? \_\_\_\_\_

- Internet \_\_\_\_\_
- Which web-site? \_\_\_\_\_
- Yellow Pages \_\_\_\_\_

**Full Name:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone Numbers: (home) (\_\_\_\_) \_\_\_\_-\_\_\_\_ (work) (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 (cell phone) (\_\_\_\_) \_\_\_\_-\_\_\_\_ (other phone) (\_\_\_\_) \_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ E-mail: \_\_\_\_\_ Name of spouse: \_\_\_\_\_

Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ (This is used as unique medical record number.)

Your Primary Care or Family Doctor: \_\_\_\_\_ Your gynecologist: \_\_\_\_\_

Other Doctors you use: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_  
 Date of Birth (of person responsible for payment): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Social Security Number (of person responsible): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Telephone Number (of person responsible): (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 Address (of person responsible): (street/box) \_\_\_\_\_ (city & state) \_\_\_\_\_ (zip) \_\_\_\_\_  
 Employer (of person responsible): \_\_\_\_\_

Primary (first) Insurance Company: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary (second) Insurance Company: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I have been provided HIPPA privacy policy information and I now grant permission to copy and transfer medical records in order to determine insurance eligibility and to promote continuity of excellent healthcare for myself or the above named person I represent. I understand that my permission may be revoked at any time upon my written and signed request.

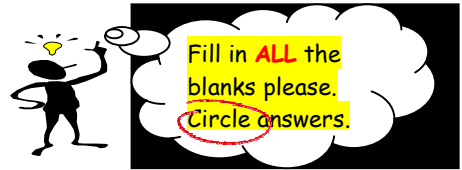
X \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand that physicians may recommend or require certain standard, desirable or necessary healthcare products for me or the person I represent; however, Medicare, Medicaid or other third party insurers may not pay or approve these.

X \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand that I have a right to decline any or all forms of testing, medication, treatment and surgery before the these treatments are rendered and I may question Medicare, Medicaid and my insurer as to payment benefits which I may expect for myself or the person I represent. However, I also understand that I am personally responsible for immediate payment of reasonable and customary charges for any service not otherwise paid by Medicare, Medicaid or my insurer. I understand that my payment is due on or before the time and date the medical product or service is provided.

X \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_



CC/HPI

How old are you presently? \_\_\_\_\_

Why are you here to see the doctor today? (Please do NOT write "checkup" or "appointment" or "doctor sent me." Be very specific.)

Please complete this sentence: I am worried about ..... \_\_\_\_\_

What part of your body is affected? **Left..Right** \_\_\_\_\_ How bad is the problem? **Mild..Mod..Severe**

Referring to the reason that you are here, how long has this been ongoing? \_\_\_\_\_

What makes the problem better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

How often does the problem happen? **Continuously....Off & On....Daily....Nightly....Weekly....Monthly....Yearly**

How long does the problem usually last? \_\_\_\_\_ Any associated problems? \_\_\_\_\_

Have you EVER had the same or a similar problem previously? \_\_\_\_\_

Have you EVER seen a urologist? **Yes..No** Which urologist? \_\_\_\_\_ What year? \_\_\_\_\_

What diagnosis? \_\_\_\_\_ Which treatment(s) worked? \_\_\_\_\_

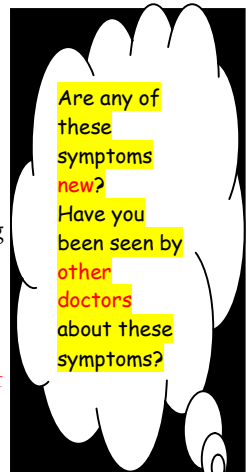
Which treatment(s) did not work? \_\_\_\_\_

When was your **last menstrual period?** \_\_\_\_\_ ... last **mammogram?** \_\_\_\_\_ ... last **colonoscopy?** \_\_\_\_\_

# Review of Systems

Have you had any of the following list of problems lately? Check the appropriate boxes.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fever (temperature greater than 100.3 degrees) | <input type="checkbox"/> Fainting  | <input type="checkbox"/> Weakness            |
| <input type="checkbox"/> Numbness or tingling                           | <input type="checkbox"/> Vision problems   | <input type="checkbox"/> Hearing problems    |
| <input type="checkbox"/> Abnormal skin                                  | <input type="checkbox"/> Very easy bruising  | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Chest pain                                     | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Vomiting            |
| <input type="checkbox"/> Depression                                     | <input type="checkbox"/> Severe anxiety  | <input type="checkbox"/> Back pain           |
| <input type="checkbox"/> Blood in the urine that you can see            | <input type="checkbox"/> Pain or discomfort with intercourse                                       |  |
| <input type="checkbox"/> Blood in the sputum or coughing-up blood       | <input type="checkbox"/> Constipation (hard stool) or difficulties passing stool                   |  |
| <input type="checkbox"/> Blood in the stool or black discolored stool   | <input type="checkbox"/> Pain in <i>leg muscles</i> with walking, <i>which goes away with rest</i> |  |
| <input type="checkbox"/> Unusual or heavy vaginal bleeding              |  |  |



Circle your answers concerning incontinence. 'Incontinence' means unintentional leakage of urine:

Do you accidentally wet your underwear, clothes, pads, bed or diapers? **Yes..No**

If yes, please circle answers in every row in the red box below.

- The incontinence is getting ... better ... worse ... same. I wet my ... underwear ... outer clothing ... pads ... diapers...
- How many pads of diapers do you use in a full day / 24 hours? .....1.....2.....3.....4.....5.....6.....7.....8.....more.....
- Do you leak urine continuously/non-stop/24 hours per day, like a dripping faucet? **Yes..No**
- On a 1-10 scale, how bad / bothersome is this? (1 is mild, 10 is severe).....1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....
- Does the urge to urinate cause you to leak urine (for example -- leaking urine on the way to restroom)? **Yes..No**
- When did the urge incontinence first start? \_\_\_\_\_
- Do you accidentally leak urine with physical actions like ... cough ..... strain ..... laugh ..... exercise ..... none of these.
- When did the incontinence with physical activity first start? \_\_\_\_\_
- Which type of leakage is worse for you? .... leakage with physical activity (or) leakage with sudden urge to urinate

Circle your answers concerning cystitis. 'Cystitis' means bladder infection or inflammation?

Have you ever had cystitis/bladder infection/UTI? **Yes..No** If yes, circle answers in every row in the red box below.

- How many times in the last year/12 months have you had cystitis? .....1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....
- When was first time ever, that you had cystitis? \_\_\_\_\_ When was the last time? \_\_\_\_\_
- Have you ever been catheterized? **Yes..No** What doctor(s) has treated you for this problem? \_\_\_\_\_
- Have you noticed that this problem often occurs 1-2 days after sexual intercourse? **Yes..No**

Circle an answer in every row in the table below concerning how you have been urinating within the last week.

<b>Incomplete Empty</b> -- After I urinate, my bladder feels like it may not be completely empty. This happens ... (circle answer in this row)	Never	Almost never	Less than half the time	About half the time	More than half the time	Almost always
<b>Frequency</b> -- Sometimes I have to go urinate more than once within two hours. This happens ... (circle answer in this row)	Never	Almost never	Less than half the time	About half the time	More than half the time	Almost always
<b>Intermittency</b> -- Sometimes my urine stream stops and restarts. This happens ... (circle answer in this row)	Never	Almost never	Less than half the time	About half the time	More than half the time	Almost always
<b>Urgency</b> -- Sometimes I have sudden urges to urinate. When I have to go, I really have to go. This happens ... (circle answer in this row)	Never	Almost never	Less than half the time	About half the time	More than half the time	Almost always
<b>Weak Stream</b> -- Sometimes I have a weak or slow urine stream? This happens ... (circle answer in this row)	Never	Almost never	Less than half the time	About half the time	More than half the time	Almost always
<b>Hesitancy</b> -- Sometimes I have trouble getting my urine stream started? This happens ... (circle answer in this row)	Never	Almost never	Less than half the time	About half the time	More than half the time	Almost always
<b>Nocturia</b> -- Sometimes I get up from sleep to urinate. This happens ... (circle answer in this row)	Never	One time	Two times	Three times	Four times	Five or more
<b>Total &gt;&gt;</b>						<input type="text"/>
<b>Bother</b> -- At times, some of these symptoms may be bothersome. The above symptoms bother me ... (circle answer in this row)	None	Almost none	Somewhat	Moderately	A lot	Severely
<b>Term Drib</b> -- Sometimes urine continues to dribble out after I think I'm finished urinating? This happens ... (circle answer in this row)	Never	Almost never	Less than half the time	About half the time	More than half the time	Almost always
<b>Dysuria</b> -- Do you currently experience burning or pain while urinating? (circle answer in this row)	Yes	No				



# Surgical History

Please circle an answer in every row below, then list any and every additional surgery that you have ever undergone.

Have you had a hysterectomy? **Yes...No** If yes, **what year** was this done? \_\_\_\_\_

Where did the surgeon make the incision to remove the uterus? .... lower abdomen .... inside vagina ....

Have you had an ovary removed? **Yes...No... I don't know** If yes, **what year** was this done? \_\_\_\_\_

Which ovary was removed? .... left .... right .... both .... small part of one ovary .... I don't know ....

Have you had a tubal ligation or 'tubes tied'? **Yes...No**

Have you had 'bladder surgery' or other vaginal/pelvic surgery? **Yes..No** If yes, **what year** was this done? \_\_\_\_\_

What was the name of the surgery? slings ... bladder suspension ... A/P repair ... cystocele .... rectocele ... C-section ... other

Did you have incontinence *before* the bladder/pelvic surgery? **Yes...No** Incontinence *after* the surgery? **Yes...No**

Please list every surgery of every type that you have ever undergone, along with the year it was done.

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# Medical History

Please list all of your medications here. If you have an accurate list, provide it to our receptionist.

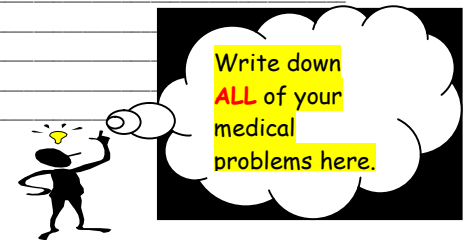
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# Medications

Please list all of your medications here.

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Are you allergic to any medication or allergic to IV contrast/dye? \_\_\_\_\_

# Family History

Have any of your blood relatives had these or other diseases?

Diabetes (who? \_\_\_\_\_)

Breast cancer (who? \_\_\_\_\_)

None -- No medical problems run in family.

List other family medical problems here. \_\_\_\_\_

# Social History

What city or town do you live in? \_\_\_\_\_ Where did you grow up? \_\_\_\_\_

Are you married? **Yes..No** How many children do you have? ...0...1...2...3...4...5...6...7...8...9...10...

Are you sexually active? **Yes..No** (That is, do you currently have a partner with whom you have intercourse? Your answer is very important as it pertains to certain urological conditions such as cystitis, infections, prostatitis, sexual dysfunction, incontinence and many others. All answers are confidential to your medical record!)

What kind of work do you do presently? \_\_\_\_\_

Does your job require heavy physical activity? \_\_\_\_\_

What type of physical activity or exercise do you regularly perform? \_\_\_\_\_

Do you smoke? **Yes..No** Have you ever smoked? **Yes..No** When did you stop smoking? \_\_\_\_\_

Do you drink coffee, "cokes" or tea which contain **caffeine**? **Yes..No** How much? \_\_\_\_\_

Do you drink **alcohol**? **Yes..No** How much can you/do you drink? \_\_\_\_\_

Do you use or smoke any illegal "street" drugs? \_\_\_\_\_

STOP HERE -- PLEASE DO NOT WRITE BELOW THIS LINE -- STOP HERE -- PLEASE DO NOT WRITE BELOW THIS LINE --  
STOP HERE -- PLEASE DO NOT WRITE BELOW THIS LINE -- STOP HERE -- PLEASE DO NOT WRITE BELOW THIS LINE --

**GENERAL**

- GEN: well-developed, well nourished, no acute distress, no gross bodily deformities, respiratory rate normal, pulse rate normal and regular, temperature normal \_\_\_\_\_
- GI: abdomen without masses, nondistended, nontender, no organomegaly, no hernia \_\_\_\_\_
- HEENT: normocephalic \_\_\_\_\_
- eyes: normal appearing, no color change \_\_\_\_\_
- neck: normal appearing, supple, no increased jugular venous distention, no thyroid masses, no masses \_\_\_\_\_
- lungs: CTA bilaterally, no WRR, normal respiratory excursions \_\_\_\_\_
- cardiovascular: RRR, no MRG, radial and popliteal pulses three plus bilaterally, no significant pretibial nor presacral edema no carotid bruits \_\_\_\_\_
- chest: normal, no masses, nontender \_\_\_\_\_
- lymph: no adenopathy of the neck, axilla, growing or other location \_\_\_\_\_
- musculoskeletal: no orthopedic abnormalities, no midline defects, no edema, no CVA tenderness \_\_\_\_\_
  
- extremities: no clubbing, cyanosis nor edema, no orthopedic abnormalities \_\_\_\_\_
- psychiatric: oriented to PPTS, normal thought content, no suicidal ideation, mood appropriate for situation \_\_\_\_\_

**FEMALE (1 -- 6 -- 7+3 -- 7+11 -- 7+11)**

- external genitalia: normal appearing, normal hair distribution for age, no visible lesions \_\_\_\_\_
- meatus: normal size and location, no lesions, no discharge, no prolapse \_\_\_\_\_
- urethra: no masses, nontender, no visible scarring \_\_\_\_\_
- bladder: no masses, nontender, nondistended \_\_\_\_\_
- vagina: normal mucosa, no visible lesions, no significant atrophic changes, no unusual discharge, no significant prolapse
  - cystocele.....grade 1,2,3,4                       rectocele.....grade 1,2,3,4                       stress test (+/\_)
  - atrophy.....grade 1,2,3,4     enterocele.....grade 1,2,3,4     vault prolapse.....grade 1,2,3,4     Kegel.....grade 0,1,2,3
- cervix: no masses, nontender, examination consistent with surgical history outlined above \_\_\_\_\_
- uterus: no masses, nontender, examination consistent with surgical history outlined above \_\_\_\_\_
- adnexa/parametria: no masses, nontender, no organomegaly, examination consistent with surgical history outlined above \_\_\_\_\_
- rectum: no masses, nontender, no significant hemorrhoids, normal sphincter tone, non-bloody stool \_\_\_\_\_
- perineum: no masses, nontender, normal anus, no significant movement of perineal body with straining \_\_\_\_\_

**ASSESSMENT:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLAN/RECOMMENDATION:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The patient/parent(s)/guardian(s) read and signed CONSENT form(s) for the procedure(s) performed or proposed as outlined above or dictated. ALL questions were answered to the satisfaction of all parties present, prior to proceeding with the procedure(s).

The above described or dictated COUNSELING session and visit lasted for \_\_\_\_\_ minutes and the majority of this time was spent counseling.

All images regarding the RADIOGRAPHIC STUDIES described herein and dictated were comprehensively reviewed for urology specific reasons for evaluation and treatment including possible surgical planning. A separate report of these findings is dictated.

The RISKS, potential BENEFITS and all OPTIONS (including the options for no treatment) for the procedure(s) performed or proposed as outlined above or dictated, were discussed with the patient/parent(s)/guardian(s) in detail to the satisfaction of all parties present. There are no exceptions except as written here: \_\_\_\_\_.

The absolute requirement for close and careful medical and urological FOLLOW-UP (for lifelong basis in the case of known or suspected cancer/tumor, stone, neurologic disease and other chronic conditions) was emphasized and the patient's/parent(s)/guardian(s)' responsibility for such was defined clearly in understandable layman's terms. The risks of failure to do so were described and emphasized.

The EVALUATION and TREATMENT PLANS were discussed with the patient/parent(s)/guardian(s) in understandable layman's terms and all parties present expressed their understanding, agreement, responsibility and request to proceed as outlined above or dictated. Exceptions are none, unless written here: \_\_\_\_\_.

U/S PVR \_\_\_\_\_ cc

BP \_\_\_\_\_ / \_\_\_\_\_ L / R

\_\_\_\_\_, M.D.