

How did you find out about our services? M

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: \_\_\_\_\_

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.

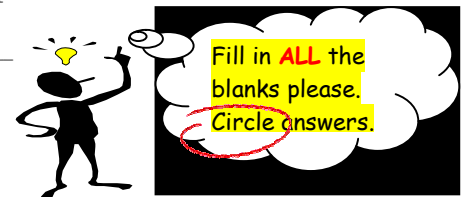
~~X~~ \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

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? \_\_\_\_\_

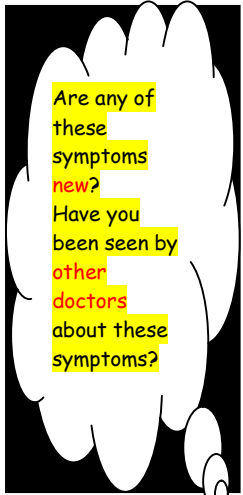
Which treatment(s) did not work? \_\_\_\_\_

What was your **last PSA** number? \_\_\_\_\_ When was the **PSA** done? \_\_\_\_\_ When was your 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 <b>you</b> can see     |  |  |
| <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 <b>leg muscles</b> with walking, <b>which goes away with rest</b> |  |



Circle your answers concerning incontinence, which 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 leakage is getting ... **better** ... **worse** ... **same**. Do you wet the ... **underwear** ... **outer clothing** ... **pads** ... **diapers**...  
 When did the incontinence **first** start? \_\_\_\_\_  
 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**  
 Do you accidentally leak urine with **physical** actions like ... **cough** ..... **strain** ..... **laugh** ..... **exercise** ..... **none of these**.  
 Which type of leakage is worse for you? .... leakage with **physical activity** (or) leakage with **sudden urge** to urinate



Circle your answers concerning sexual issues: erectile dysfunction (**ED**), impotence, libido & premature ejaculation.

Do you have premature ejaculation? **Yes..No** Is your desire for sex (libido) decreased? **Yes..No**

Do you have trouble with penile erections? **Yes..No** The ED started .. <1.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....>10.. years ago.

Would you like to discuss treatment with the doctor? **Yes..No** If yes, complete ALL questions in red box below.

The ED is getting... **better** .. **worse** .. **same**. Are you able to get a penile erection at all? **Yes..No** \_\_\_\_\_  
 On a 1-10 scale, how bad / bothersome is the ED? (1 is mild, 10 is severe).....1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....  
 What treatments have you tried?  
 \_\_\_\_\_  
 Does the penis become as firm or hard as it should? **Yes..No** \_\_\_\_\_  
 Do you tend to lose the erection during intercourse, even **before** climax? **Yes..No** \_\_\_\_\_  
 Did the ED start about the same time that you started a new medication or changed medications? **Yes..No** \_\_\_\_\_  
 When the ED first started, was the penis curved, **bent** or **crooked** when it was fully erect? **Yes..No** \_\_\_\_\_  
 Do you currently have a sex **partner**? **Yes..No** Is your partner **supportive** about having the ED treated? **Yes..No**

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

	Never	Almost never	Less than half the time	About half the time	More than half the time	Almost always
<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				



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 --

MALE (1 -- 3 -- 9+3 -- 9+11 -- 9+11)

- testes: bilaterally descended, normal volume, no gross dissymmetry, no masses, nontender \_\_\_\_\_
- scrotum: normally developed, non-discolored, no crepittance, no lesions, no cysts, no rashes \_\_\_\_\_
- epididymis: bilaterally without gross dissymmetry, normal volume, no masses, no unusual tenderness \_\_\_\_\_
- phallus: normal male, normal meatus, normal sensory, (circ/non-circ), no significant phimosis, no palpable plaque, no masses \_\_\_\_\_
- meatus: normal size and location, no lesions, no discharge \_\_\_\_\_
- perineum: no masses, nontender, normal anus \_\_\_\_\_
- prostate: nonnodular, nontender, symmetric, nonfluctuant, approximately \_\_\_\_\_ grams \_\_\_\_\_
- seminal vesicles: bilaterally probably normal, nontender, no masses \_\_\_\_\_
- rectum: no masses, nontender, normal sphincter tone, no significant hemorrhoids, non-bloody stool \_\_\_\_\_

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 \_\_\_\_\_

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, neuralgic 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.