How did you find out about our services? F

[ ] Another Person … Who? _____ [ ] Internet _____

[ ] Another Doctor … Who? _____ Which web-site? _____

[ ] Other … How? _____ [ ] 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.

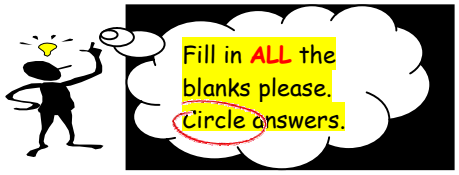
X_____ DATE: _____/_____/_____

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? _____

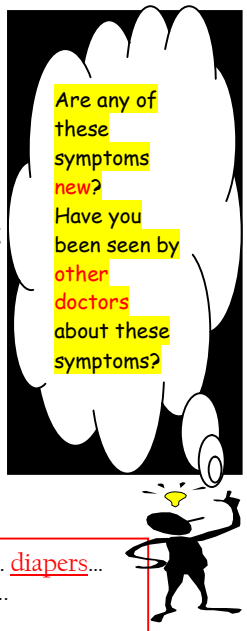
Have you EVER seen a urologist? Yes..No Which urologist? _____ What year? _____

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.

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

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.

Incomplete Empty -- 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**
Frequency -- 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**
Intermittency -- 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**
Urgency -- 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**
Weak Stream -- 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**
Hesitancy -- 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**
Nocturia -- 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**
					Total >>	
Bother – 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**
Term Drib -- 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**
Dysuria -- 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? sling ... 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.

_____

_____

_____

_____

Medical History

Please list any and every medical problem/diagnosis which you have been given by a doctor. Do not list surgeries here.

_____

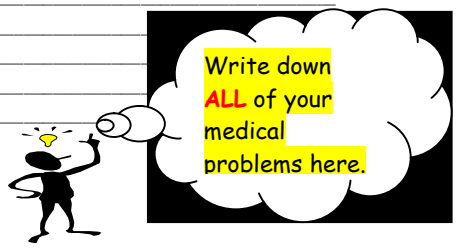
_____

_____

_____

_____

_____



Medications

Please list all of your medications here.

_____

_____

_____

_____

_____

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.