

How did you find out about our services?

C

Another Person ... Who? _____
 Another Doctor ... Who? _____
 Other ... How? _____

Yellow Pages _____
 Newspaper _____
 Internet _____

Full Name: _____ 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.

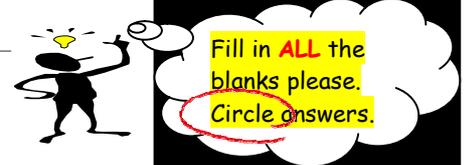
~~X~~ _____ DATE: ____/____/____

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**. The doctor can help only if he understands, the **exact** medical problem for which you need attention and care today.)

Please complete this sentence: I am worried about
Referring to the reason that you are here, what part of your body is affected?left.....right.....
Referring to the reason that you are here, how severe is the problem? mild.....moderate.....severe.....
Referring to the reason that you are here, how long has this been going on?
What makes the problem better? _____ What makes it worse? _____
How often does the problem happen?continuously.....daily.....weekly.....monthly.....yearly.....
How long does the problem usually last? _____
Are there any associated problems? _____
Have you had the same or a similar problem previously? _____
Have you ever been seen by a urologist for this problem? _____ What was the urologist's name? _____
What year were you evaluated by the urologist? _____ What did the urologist's diagnosis? _____
Which treatment worked? _____ Which treatment did not work? _____

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"/> Burning while passing urine |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Burning just after passing urine |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Urinating frequently in the daytime |
| <input type="checkbox"/> Severe anxiety | <input type="checkbox"/> Urinating frequently in the nighttime |
| <input type="checkbox"/> Stress in your home life | |
| <input type="checkbox"/> Difficulty sleeping | |
| <input type="checkbox"/> Blood in the urine that you can see | |
| <input type="checkbox"/> Blood in the stool or black discolored stool or vomiting blood | |
| <input type="checkbox"/> Constipation (hard stool) or difficulties getting stool to pass | |
| <input type="checkbox"/> Decreased force of the urine stream | |
| <input type="checkbox"/> Feeling of incomplete emptying of the bladder | |
| <input type="checkbox"/> Sudden severe urge to pass urine, even though you just recently urinated | |
| <input type="checkbox"/> Arising from sleep at night to urinate -- How many times per night?
.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....11.....12..... | |

If you check a red box, fill in **ALL** of the questions beneath the box. Give as much detail as possible.



- Incontinence or accidental leakage of urine causing you to wet your underwear, clothes, pads, the bed or diapers. (If you check this, please answer ALL of the questions within the box below.)

How have you or your parents or other doctors tried to manage this problem in the past? _____

Has any treatment worked for you? _____

Who is more interested in getting this problem fixed, you or your parents? _____

Is this getting worse? _____

Have you ever gone six months without leaking/wetting at all? _____

If yes, why do you or your parents feel that the problem started again? _____

At what age (in years) were you potty trained? _____

If leakage occurs at night, how many **nights** per week?1.....2.....3.....4.....5.....6.....7.....

If leakage occurs in the day, how many **days** per week?1.....2.....3.....4.....5.....6.....7.....

Do you leak urine **continuously**, like a dripping faucet? _____

Do you delay urinating for long periods of time, until the "last minute?" _____

Do you commonly get a sudden severe **urge** to pass urine? _____

Does the **urge** feeling cause you to leak urine (for example -- leaking or wetting on the way to restroom)? _____

When did the urge type leakage occur the very first time? _____

Do you push on the genital area with your hand or your heel as if to stop the urge to urinate? _____

Do you squat down as if to stop the urge to urinate? _____

Which physical activities are associated with the leakage?
.....**cough**.....**sneeze**.....**strain**.....**laugh**.....**exercise**.....**walk**.....**other physical activity**.....

When did the physical activity type leakage occur the very first time? _____

On a 1-10 scale, how much does the leakage bother you? (1 indicates little bother and 10 indicates a severe bother)1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....

How many incontinence **pads** do you use on an average day? _____

How wet do the pads or diapers get?a little.....moderately wet.....soaked.....

Which type of leakage is worse for you? leakage with **physical activity** (or) leakage with **sudden urge** to urinate

Do you have relatives who have had childhood leakage problems? _____

Who has/had this problem? _____ At what age did the leakage stop? _____

- Bladder infections or cystitis (If you check this, please answer ALL of the questions within the box below.)

How many **times per year** do you have this problem?**less than 4**.....**more than 4**.....

When did you have the **first** infection or cystitis episode? _____ When was the **last** time? _____

Have you ever been **catheterized**? _____ What doctor(s) has treated you for this problem? _____

Did the doctor prove your problem was caused by an infection by **growing bacteria** from your urine on a **culture**? _____

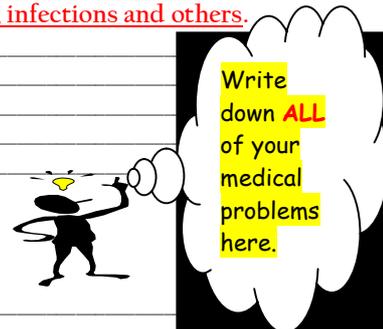
Have you ever had **fever** as high as 101 degrees with the infections? _____

Surgical History

Please list any and every surgery that you have ever undergone here.

Medical History

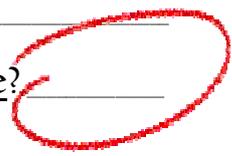
Please list any and every medical problem and diagnosis which you have been given by a doctor. Include all heart, lung, kidney, high blood pressure, stroke, cancer problems and all other medical problems. Give very detailed information about all urology problems and treatments such as cancer, incontinence, stones, infections and others.



Medications

Please list all medications that you currently use?

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?

- Childhood enuresis/incontinence/wetting
- Childhood diabetes
- Other childhood diseases _____

List other family medical problems here. _____

Social History

What city or town do you live in? _____

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

Which adult(s) do you live with? _____

How old are your brothers? _____

How old are your sisters? _____

What school do you attend and what do you study? _____

Do you smoke? _____

Do you drink coffee, "cokes" or tea which contain caffeine? _____ How much? _____

Do you drink alcohol? _____ 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 --

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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 _____
- 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 _____
- 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 _____
- 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 _____
- 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

_____, M.D.