Name: _____ Referring MD: _____ Date: _____

DOB: ____/____/____ Level of Education: _____ Occupation: _____

Martial Status (please circle): **Single / Married / Partnered / Widowed / Divorced** Height: _____ Weight: _____

Do you have allergies? **Yes / No** If yes, please list: _____

_____

Please describe the reason for today's visit: _____

_____

Location? _____ When did you first notice it? _____

Associated symptoms? _____

Does anything improve it? **Yes / No** _____ Make it worse? **Yes / No** _____

Communication issues? **Yes / No** _____ Do you have an Advanced Directive? **Yes / No**

Spoken language(s): _____ Race: _____

Email Address: _____

Do you smoke or use tobacco products? **Yes / No** If yes, how many packs per day? _____ How many years? _____

Do you drink alcoholic beverages? **Yes / No** If yes, how many drink per day? _____ Do you use drugs? **Yes / No**

Please list all of your current medications, dosage, frequency, and the reason for taking them.

Medication	Dose	Frequency	Reason for taking

PATIENT PAST MEDICAL HISTORY: Please list any medical conditions either current or past.

❑ Heart Disease	❑ Heart Attack	❑ Stroke
❑ Diabetes - On insulin? Yes / No	❑ Cancer (please specify type)	❑ Hypertensions (High Blood Pressure)
❑ High Cholesterol	❑ Prostate Cancer	❑ Bowel Problems
❑ Kidney Stones	❑ Kidney Disease	❑ Dialysis
❑ Pacemaker/Defibrillator	❑ Bleeding Problems	❑ Alzheimer's
❑ Lung Disease	❑ Liver Disease	❑ Epilepsy or Seizures
❑ Other:		

PATIENT SURGICAL HISTORY: Please list any surgeries you have had and the year they were performed.

Surgery	Year of Surgery

FAMILY MEDICAL HISTORY: Please list any medical conditions in your family and specify which family member.

Condition	Family Member	Condition	Family Member

Review of systems: Please check if you have any of these symptoms recently. **Please check NONE if none of the symptoms are present.**

General ❑ Fever ❑ Chills ❑ Headaches ❑ Weight loss ❑ Other: _____ ❑ None	**Eyes** ❑ Double vision ❑ Blurred vision ❑ Glaucoma ❑ Cataracts ❑ Other: _____ ❑ None	**Neurologic** ❑ Dizziness ❑ Numbness/Tingling ❑ Difficult balance ❑ Other: _____ ❑ None	**Gastrointestinal** ❑ Abdominal pain ❑ Constipation ❑ Diarrhea ❑ Rectal bleeding ❑ Use antacids ❑ Other: _____ ❑ None
Ear/Nose/Throat/Mouth ❑ Hearing loss ❑ Dentures ❑ Nose bleeds ❑ Sore throat ❑ Other: _____ ❑ None	**Cardiovascular** ❑ Chest pain ❑ Heart disease ❑ Blood pressure ❑ Heart murmur ❑ Ankle swelling ❑ Other: _____ ❑ None	**Respiratory** ❑ Shortness of breath ❑ Chronic cough ❑ Emphysema ❑ Tuberculosis ❑ Other: _____ ❑ None	**Hematological** ❑ Clotting disease ❑ Anemia ❑ Other: _____ ❑ None
Psychological ❑ Depression ❑ Anxiety ❑ Other: _____ ❑ None	**Genitourinary** ❑ Painful urination ❑ Frequent or urgent urination ❑ Urine leakage ❑ Urinary tract infections ❑ Blood in urine ❑ Kidney problems ❑ Other: _____ ❑ None	**For Men** ❑ Erection problems ❑ Testicular lump ❑ Prostrate procedure ❑ Elevated PSA ❑ Other: _____ ❑ None	**Genitourinary** ❑ Pregnancies #: _____ ❑ Vaginal deliveries #: _____ ❑ Difficult deliveries? ❑ Other: _____ ❑ None

erlanger Urology

PERMISSION FORM

Name: _____ DOB: ____/____/____

Home #: _____ Cell #: _____ Work #: _____

May we leave medical information on your voicemail or answering machine? (circle) **Y / N**

In the event that we are unable to contact YOU, please list the names and phone numbers of any family member(s) or friends that we may discuss your patient information with; by signing this form, you are giving Erlanger Urology permission to speak with and/or leave messages regarding test results, procedure scheduling, future appointments, medication issues, or any other instructions on your voicemail or with the person(s) listed below. This information will remain effective for the duration of your care unless terminated in writing by you.

Authorize Person(s)	Relationship	Phone #

Patient Signature: _____ Date: _____

PATIENT INFORMATION

Name: _____ DOB: ____/____/____

Address: _____ City/State/Zip: _____

SS #: _____ Home #: _____ Cell #: _____

Is it okay to leave a voicemail/message on your phone regarding medication, labs, appointments, instructions? **Yes / No**

Employer: _____ Work #: _____

Employer Address: _____ City/State/Zip: _____

INSURANCE *(Please give your insurance card(s) to the receptionist)*

Primary Insurance: _____ Policy #: _____ Group #: _____

Insured Name: _____ DOB: ____/____/____ SS #: _____

Relationship to insured (please circle): **Self / Spouse / Child / Other**

Secondary Insurance: _____ Policy #: _____ Group #: _____

Insured Name: _____ DOB: ____/____/____ SS #: _____

Relationship to insured (please circle): **Self / Spouse / Child / Other**

EMERGENCY CONTACT

Name 1: _____ Phone #: _____ Relation: _____

Address: _____ City/State/Zip: _____

Is it okay to leave a voicemail/message on their phone regarding medication, labs, appointments, instructions? **Yes / No**

Name 2: _____ Phone #: _____ Relation: _____

Address: _____ City/State/Zip: _____

Is it okay to leave a voicemail/message on their phone regarding medication, labs, appointments, instructions? **Yes / No**

PHARMACY

Pharmacy Name: _____ Phone #: _____ Fax #: _____

Medication/Food Allergies? **Yes / No** If yes, please list: _____

PHYSICIANS *(Please list first and last name)*

Primary Care Physician: _____ Phone #: _____ Fax #: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

Cardiologist: _____ Phone #: _____ Fax #: _____

Other: _____ Phone #: _____ Fax #: _____

erlanger Urology

American Urological Association's Benign Prostatic Hypertrophy Symptom Score Index

Symptom Questions	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	SCORE
How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
How often have you stopped and started again several times when you urinated?	0	1	2	3	4	5	
How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
How often have you had a weak urinary stream?	0	1	2	3	4	5	
How often have you had to push or strain to begin urinating?	0	1	2	3	4	5	
How many times do you typically get up to urinate from the time you go to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
Total symptom score *(Add the score for each number above and write the total in the space to the right.)*							

SYMPTOM SCORE: 1–7 (Mild) 8–19 (Moderate) 20–35 (Severe)

Quality of Life	Delighted	Pleased	Mostly Satisfied	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now for the rest of your life?	0	1	2	3	4	5

MD Review: _____ Date: _____