

Today's Date: _____

Account number: _____

DEAR PATIENT: We have made every attempt to reduce the amount of paperwork that you need to fill out and also make the process more efficient. Your cooperation and correct completion of the information below will assist us in obtaining the information correctly the first time. Please provide a copy of your primary and secondary (if applicable) insurance card to the front desk with your paperwork. **THANK YOU**

Is your condition a result of a work injury? _____ Or related to an auto accident? _____

PATIENT INFORMATION:

SS #: _____ DL #: _____

Last name: _____ First name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____ Email: _____ DOB: _____

AGE: _____ M: _____ F: _____ Marital Status: _____

Your Employer: _____ Occupation: _____

Work Address: _____ City: _____

State/ Zip: _____ Work #: _____ Work Email: _____

Emergency Contact: _____ Phone #: _____ Cell #: _____

Patient relationship to primary cardholder: Self: _____ Spouse: _____ Other: _____

If you are not the primary cardholder please complete next box.

PRIMARY AND SECONDARY CARDHOLDER INFORMATION: Please complete this section if the patient is not the primary cardholder for their primary and secondary insurance. This information is **REQUIRED BY YOUR** insurance company for identification of policyholder and correct billing.

Cardholder's name: _____ Cardholder's Occupation: _____

Cardholder's Employer: _____ Cardholder's work #: _____

Cardholder's SS #: _____ Cardholder's DOB: _____

PATIENT REFERRAL INFORMATION: Your insurance company and our office **REQUIRES** this information. **Kasraeian Urology** utilizes this information to send communication about your care to your referring and primary care physician (if appropriate).

Referring MD: (full name) _____ Phone #: _____

Primary care physician: _____ Phone #: _____

For office use:

Copy of primary card attached

Referral obtained and attached

Copy of secondary card attached

Demographic entered and attached

Waiver signed and attached

Employee Initials _____

Kasraeian Urology

Review of Systems – Please indicate any of the following symptoms or conditions that you are **CURRENTLY** having.

Constitutional

- Appetite decreased
- Appetite increased
- Anorexia
- Aches and pains
- Chills
- Cold intolerance
- Easy bruising
- Exposure to toxins or irritants
- Fever
- Fatigue
- Generalized weakness
- Headaches
- Head trauma
- Heat intolerance
- Hot flashes
- Insomnia
- Night sweats
- Recent weight gain
- Recent weight loss
- Sleep apnea
- Sleep problems
- Swollen glands
- Other: _____

Eyes

- Blind
- Blurred vision
- Cataracts
- Changes to vision
- Decreased vision
- Double vision
- Glaucoma
- Glasses
- Macular degeneration
- Pain
- Worsening eyesight
- Other: _____

Allergic / Immunologic

- Animal allergies
- Drug allergies
- Environmental allergies
- Food allergies
- Hay fever
- Seasonal allergies
- Other: _____

Neurological

- Balance problems
- Disoriented
- Dizzy spells
- Fainting spells
- Headache
- Hydrocephalus (water on the brain)
- Lack of alertness

Neurological (continued)

- Leg or arm weakness
- Memory loss
- Numbness / tingling
- Paralysis / weakness
- Seizures
- Stroke
- Speech problems
- Tremors
- Other: _____

Endocrine

- Diabetes
- Excessive thirst
- Pituitary disease
- Hypothyroidism
- Hyperthyroidism
- Tired / sluggish
- Too hot / too cold
- Other: _____

Gastrointestinal

- Abdominal cramps
- Abdominal pain
- Acid reflux
- Anal fissure / abscess
- Bloating
- Bloody stools
- Change in bowel habits
- Constipation
- Diarrhea
- Flatulence
- Food intolerance
- Gas
- Hemorrhoids
- Indigestion / heartburn
- Irregular bowel movements
- Jaundice
- Laxative use
- Nausea / vomiting
- Painful swallowing
- Rectal bleeding
- Ulcer
- Vomiting blood
- Other: _____

Cardiovascular

- Chest pain / angina
- Shortness of breath with exertion
- Shortness of breath without exertion
- Edema
- Heart attack
- Heart disease
- Heart failure
- Heart murmur
- High blood pressure
- Irregular heartbeat
- Mitral valve prolapsed
- Pain / cramps in hip or legs with exercise
- Palpitations
- Rheumatic fever
- Skipped heart beats
- Swelling
- Varicose veins
- Other: _____

Skin

- Acne
- Boils
- Breast changes
- Changing moles
- Hair loss or change
- New skin moles
- Persistent itch
- Pigment change
- Psoriasis
- Skin lumps
- Skin rash
- Other: _____

Musculoskeletal

- Arthritis
- Back pain
- Gout
- Joint pain
- Leg swelling
- Muscle cramps
- Muscle pain
- Muscle weakness
- Neck pain / stiffness
- Other: _____

Ear / Nose / Throat / Mouth

- Bleeding gums
- Congestion
- Ear infection
- Hearing loss
- Hearing problems
- Hoarseness
- Impaired hearing
- Nosebleeds
- Ringing in ears (tinnitus)
- Sinus problems
- Sore throat
- Vertigo
- Other: _____

Urinary / Genital

- Back / flank pain
- Bedwetting
- Blood in urine (hematuria)
- Dribbling
- Burning on urination
- Painful urination (dysuria)
- Hesitancy
- Intermittency
- Kidney failure
- Kidney infections
- Kidney stones
- Leaking after voiding
- Voiding at night (nocturia)
- Not emptying (urinary retention)
- Slow start
- STDs
- Straining to urinate (stranguria)
- Urgency

Urinary / Genital (continued)

- Urinary frequency
- Urinary incontinence
- Urinary tract infections
- Urologic cancer
- Weak stream
- Other: _____

OB/GYN

- Irregular periods
- Vaginal bleeding not related to menstruation
- Vaginal discharge/problems
- Other: _____

Respiratory

- Asthma
- Coughing up blood
- Difficulty breathing with exercise
- Difficulty breathing at rest
- Emphysema/bronchitis
- Environmental allergies
- Frequent cough
- Lung infections
- Productive cough
- Pneumonia
- Shortness of breath
- Tuberculosis
- Wheezing
- Other: _____

Hematological/Lymphatic

- Anemia
- Anti-inflammatory drug (NSAIDs) use
- Aspirin use
- Bleeding problem
- Blood clotting problem
- Easy bruising
- Hepatitis
- HIV / AIDS
- Sickle cell
- Swollen glands
- Other: _____

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PAST SURGICAL HISTORY - Please indicate whether and when you have had any of the following surgeries. Use last box in each category to indicate any surgeries not listed.

Cardiovascular

√	Surgery	Approximate Date
	Angioplasty	
	Coronary Artery Bypass Graft (CABG)	
	Pacemaker insertion	
	Stent placement	

OB/GYN

√	Surgery	Approximate Date
	Breast surgery	
	Delivery - cesarean	
	Delivery - vaginal	
	Endometrial ablation	
	Hysterectomy (partial)	
	Hysterectomy (total)	
	Lumpectomy of breast	
	Mastectomy	
	Tubal ligation	

General

√	Surgery	Approximate Date
	Brain Surgery	
	Laminectomy	

Gastrointestinal

√	Surgery	Approximate Date
	Appendectomy	
	Bariatric surgery	
	Colon resection	
	Colonoscopy	
	Gall bladder removal (cholecystectomy)	
	Gastric surgery	
	Inguinal hernia repair (groin)	
	Liver transplant	
	Rectal polyp	
	Rectocele repair	
	Umbilical hernia repair (navel)	

Head/ Ears/ Eyes/ Neck/ Throat

√	Surgery	Approximate Date
	Cataract surgery	
	Corneal surgery	
	Deviated septum correction (septoplasty)	
	Eye surgery	
	Sinus surgery	
	Thyroid surgery	

Genital/ Urinary

√	Surgery	Approximate Date
	Bladder biopsy (TURBT)	
	Bladder surgery	
	Cystocele repair	
	Cystoscopy	
	Laser lithotripsy/ ESWL	
	Nephrectomy	
	Prostate resection (TURP)	
	Prostatectomy - DaVinci	
	Prostatectomy – laparoscopic	
	Renal transplant	
	Ureteral stent placement	
	Urethral dilation	
	Rectocele repair	
	Prolapse Surgery	
	Urethral Sling	

Musculoskeletal

√	Surgery	Approximate Date
	Amputation	
	Back surgery	
	Foot surgery	
	Hand surgery	
	Hip surgery	
	Knee surgery	
	Rotator cuff surgery	
	Shoulder surgery	

Respiratory

√	Surgery	Approximate Date
	Lung surgery	

Skin

√	Surgery	Approximate Date
	Melanoma	

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FAMILY HISTORY - Please indicate whether anyone in your family has had the following conditions including parents, siblings, grandparents, aunts and uncles. I am adopted and I do not know my family medical history.

√	Condition	Relative(s) with Condition
	Alcoholism	
	Alzheimer's Disease	
	Arthritis	
	Asthma	
	Bladder cancer	
	Bleeding disorder	
	Breast cancer	
	Cervical cancer	
	Colon cancer	
	COPD	
	Depression	
	Diabetes	
	Glaucoma	
	Gout	
	Heart disease	
	High blood pressure	
	Kidney disease	
	Kidney stones	
	Leukemia	
	Lung cancer	
	Osteoporosis	
	Ovarian cancer	
	Prostate cancer	
	Thyroid disease	
	Uterine cancer	
	Other	

SOCIAL HISTORY

Please indicate the following.

Marital Status / Children

Single Widowed # of children
 Married Separated
 Divorced Other: _____

Alcohol Consumption

None Occasional/Social
 Yes Drinks per week
 Beers per Week

Current Tobacco Use

None Packs per day
 Yes Cigarettes per day
 Smokeless Tobacco
 Other: _____

Previous Smoking History

None How long did you smoke? _____
 Yes How many cigarettes per day on average? ____
 When did you stop? _____

Caffeinated Beverages

Low
 Moderate
 Excessive
 Cups of coffee per day: _____
 Other: _____

Recreational Drug Use

None
 Former User, Please Name Substance _____
 Current User, Please Name Substance _____
 Other: _____

MxN

BLADDER SATISFACTION SURVEY

Name _____ Phone # _____

Doctor _____

Which symptoms best describe you?

- Frequent Urination – Day, Night, or Both
- Sudden or Strong Urge to urinate
- Unable to Empty the Bladder
- Leaking with Sneezing, Coughing, Exercising
- Leaking with Urge or No Warning (Unable to make it to the bathroom in time)
- Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

- Detrol® LA
- Oxytrol® Patch
- Sanctura®
- Ditropan XL®
- Enablex®
- Elavil®
- Flomax®
- VESicare®
- Elmiron®
- Cardura®
- DDAVP®
- Other _____

Did these medications help your symptoms? Circle

0	1	2	3	4	5	6	7	8	9	10
No Relief								Completely Cured		

If you've stopped taking your meds explain why:

- Did not Help
- Side Effects
- Too Expensive

Describe Side Effects _____

Behavior Modifications Tried _____

(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle

0	1	2	3	4	5	6	7	8	9	10
Not Frustrated								Very Frustrated		

Do you currently have any problems with bowel function?:

- Fecal Incontinence
- Constipation
- Other

I am interested in learning more about treatment alternatives to medications:

- Yes
- No

