

Five Valleys Urology, PLLP

rev. 8/2010

Karl R. Westenfelder, M.D.
Garrick R. Simmons, M.D.
Kevin M. Kronner, M.D.
Christopher G. Wicher, M.D.

PATIENT INFORMATION					
NAME (Last,First, Middle)		AGE	DOB	SEX	SOCIAL SECURITY NUMBER
LOCAL ADDRESS			SEASONAL BILLING ADDRESS (If Applicable)		
CITY, STATE, ZIP			CITY, STATE, ZIP		
HOME PHONE	CELL PHONE		SEASONAL PHONE		
EMAIL ADDRESS:			May we can contact you with patient sensitive information via email? _____ YES _____ NO		
PRIMARY EMPLOYER			MARITAL STATUS	SPOUSE NAME	
OCCUPATION			NEAREST RELATIVE NOT LIVING WITH YOU		
ADDRESS			RELATIONSHIP		
CITY, STATE, ZIP		WORK PHONE	RELATIVE PHONE		
RESPONSIBLE PARTY INFORMATION (If Different than above)			REFERRING PHYSICIAN INFORMATION		
NAME	SSN#	DOB	SEX	NAME	
LOCAL ADDRESS			ADDRESS		
CITY, STATE, ZIP			CITY, STATE, ZIP		
HOME PHONE	WORK PHONE		PHONE		
RELATIONSHIP TO PATIENT			SPECIALTY		
PRIMARY INSURANCE					
NAME OF INSURANCE COMPANY			POLICY #		
NAME OF INSURED			GROUP #		
ADDRESS OF INSURANCE COMPANY			COPAY AMT		
CITY, STATE, ZIP			DEDUCTIBLE		
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE	
SECONDARY INSURANCE (IF APPLICABLE)					
NAME OF INSURANCE COMPANY			POLICY #		
NAME OF INSURED			GROUP #		
ADDRESS OF INSURANCE COMPANY			COPAY AMT		
CITY, STATE, ZIP			DEDUCTIBLE		
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE	
To the best of my knowledge, all of this is true and complete. I understand that I am responsible to pay for all services rendered to me. I am willing to make specific arrangements to pay the portion that is not covered by insurance. I grant permission to my physician to mutually exchange medical information with my referring physician(s) and/or associates. To the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of portions of the patient's medical record to my insurance carrier and/or any attorney assigned.					
SIGNATURE:			DATE:		

PATIENT HISTORY FORM

CHIEF COMPLAINT

What is the main reason for your visit today? _____

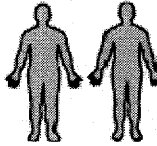
HISTORY OF PRESENT ILLNESS

Please answer the following questions

Location of the problem

Abdomen Back Leg
Other _____

Front Back



How long does the problem last?

30 minutes 1 hour It is always there
Other _____

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago
Other _____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side
Other _____

Is anything else occurring at the same time? Yes No

(If yes, please explain) _____

Do you have Nausea Rash Headaches
Other? _____

Is the problem constant or variable? Constant Variable

Dull then Sharp Very sharp then leaves Always there
Other _____

Does the problem interfere with your normal functions?

YES NO
If yes, please explain _____

PATIENT MEDICAL & SOCIAL HISTORY

Check any serious illnesses you have. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

_____ Prostate Cancer	_____ Kidney Disease	_____ Heart Problems	_____ Strokes
_____ Bladder Cancer	_____ Ulcers	_____ Lung problems	_____ Paralysis
_____ Kidney Cancer	_____ High Blood Pressure	_____ Thyroid Problems	_____ Gallstones
_____ Other Urinary Cancer	_____ Diabetes	_____ Bleeding Problems	_____ Hepatitis

Other (please explain) _____ _____ HIV/AIDS

Do you smoke? Yes No If yes, how much? _____ Do you drink? Yes No If yes, how much? _____
Do you use drugs? Yes No If yes, what kind and how often? _____ Have you been treated for alcohol/drug abuse? _____
Occupation: _____ Previous Occupation (If Retired): _____ Marital Status: _____

FAMILY HISTORY

Mother Living? Yes No If no, list cause of death & age _____ List any major problems they have/had _____
Father Living? Yes No If no, list cause of death & age _____
List how many brothers you have: _____ sisters: _____ List any major problems they have/had _____
How many children do you have? _____ List any major problems they have/had _____
If not living, list the cause of death and age (please identify as brother, sister, or child) _____

Is there any history of prostate cancer in your family? Yes No If yes, who? _____

PAST SURGERIES: (Include date) _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever	Y	N	Headache	Y	N
Chills	Y	N	Other _____		

Eyes

Blurred Vision	Y	N	Double Vision	Y	N
Pain	Y	N	Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N	Sinus problems	Y	N
Sore throat	Y	N	Other _____		

Respiratory

Wheezing	Y	N	Shortness of breath	Y	N
Frequent cough	Y	N	Other _____		

Gastrointestinal

Abdominal Pain	Y	N	Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N	Other _____		

Genitourinary

Urine retention	Y	N	Urinary frequency	Y	N
Painful urination	Y	N	Other _____		

Musculoskeletal

Joint pain	Y	N	Back pain	Y	N
Neck pain	Y	N	Other _____		

Integumentary

Skin rash	Y	N	Boils	Y	N
Persistent itching	Y	N	Other _____		

Neurological

Tremors	Y	N	Numbness/tingling	Y	N
Dizzy spells	Y	N	Other _____		

Endocrine

Excessive thirst	Y	N	Tired/sluggish	Y	N
Too hot/cold	Y	N	Other _____		

Cardiovascular

Chest Pains	Y	N	Varicose veins	Y	N
High blood Pressure	Y	N	Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N	Blood clotting problem	Y	N
Other _____					

Allergic/Immunologic

Hay Fever	Y	N	Drug allergies	Y	N
Other _____					

Psychologic

Are you generally satisfied with your life?	Y	N		
Do you feel severely depressed?	Y	N		
Have you considered suicide?	Y	N		
Other _____				

Please explain any Yes answers here.

Physician use only: (Comments/Notes)

#Answer Service	Level of
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Signature: _____ Date: ____ / ____ / ____

FEMALE PATIENT HISTORY

AGE _____ HEIGHT _____ WEIGHT _____

PRIMARY CARE PHYSICIAN (FAMILY DOCTOR) _____

REASON FOR VISIT (What are the main reasons for your visit to the doctor today?) _____

Do you have or have you recently had any of the following? Please circle your response.

- | | | |
|--|-----|----|
| ▪ Blood in your urine..... | YES | NO |
| ▪ Burning or pain when you urinate..... | YES | NO |
| ▪ Back Pain..... | YES | NO |
| ▪ Leakage of urine when coughing, straining or sneezing..... | YES | NO |
| ▪ Kidney or bladder stones..... | YES | NO |
| ▪ Urinary tract infections..... | YES | NO |
| ▪ Bedwetting or daytime wetting of clothes..... | YES | NO |
| ▪ History of sexually transmitted disease (herpes, gonorrhea, Chlamydia, etc.. | YES | NO |
| ▪ Pain with sexual intercourse..... | YES | NO |
| ▪ Skin problems in the genital or groin area..... | YES | NO |
| ▪ Fertility problems..... | YES | NO |
| ▪ Awaken frequently at night to urinate..... | YES | NO |
| ▪ Weak, dribbling stream or trouble starting your urine..... | YES | NO |
| ▪ Have you ever had kidney x-rays performed (IVP or ultrasound)?..... | YES | NO |
| ▪ Are you currently pregnant or trying to become pregnant?..... | YES | NO |

OB/GYN HISTORY

How many times have you been pregnant? _____ How many vaginal deliveries? _____ How many c-section deliveries? _____ Number of miscarriages? _____ What method do you use to prevent pregnancy? _____	Date of your last period? _____ Date of your last pap smear? _____ Have you had a hysterectomy? _____ Have you had an Oophrectomy? _____ Menopause? (If yes, date of onset) _____
--	---