Five Valleys Urology, PLLP

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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)

NAME	SSN#	DOB	SEX

LOCAL ADDRESS
CITY, STATE, ZIP

HOME PHONE	WORK PHONE

RELATIONSHIP TO PATIENT

REFERRING PHYSICIAN INFORMATION

NAME
ADDRESS
CITY, STATE, ZIP
PHONE
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:***

MEDICATION HISTORY

CURRENT MEDICATIONS: (Prescription & non-prescription, vitamins, homeopathic & home remedies, birth control)

[PLEASE LEAVE THIS AREA BLANK IF NO MEDS OR ATTACHING SHEET]

Medication	Frequency (how many times a day)	Date Started	Notes	Date Added to List

ALLERGIES TO MEDICATIONS: (List any medications you have adverse reactions to or that you are allergic to)

Are you taking any blood thinners or anticoagulants?________ Which ones?______________________________________

[For office use only]

REVIEW OF SYSTEMS/MEDICAL HISTORY LOG

Date										
Nurse										
MD										

FIVE VALLEYS UROLOGY
WESTENFELDER · SIMMONS · KRONNER · WICHER

PATIENT HISTORY FORM

CHIEF COMPLAINT

What is the main reason for your visit today?____

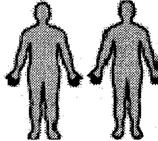
____

HISTORY OF PRESENT ILLNESS

Please answer the following questions

Location of the problem
Abdomen   Back   Leg
Other______________________________

Front   Back



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______________________________

How long does the problem last?
30 minutes   1 hour   It is always there
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
			______HIV/AIDS

Other (please explain)____

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

Physician: ______________________ Signature: ______________________ Date: _____/_____/_____

FIVE VALLEYS UROLOGY
WESTENFELDER · SIMMONS · KRONNER · WICHER

MALE PATIENT HISTORY

Label Here

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

Back pains in Kidney area.......... YES NO

Discharge from the penis........... YES NO

Urinary tract infections.............. YES NO

Pain with sexual intercourse.........YES NO

Fertility problems ....YES NO

Undescended testicle(s)..............YES NO

Have you ever had kidney x-rays performed (IVP or ultrasound)?.......YES NO

Burning or pain when you urinate........... YES NO

Loss of urine when coughing, straining or sneezing........................... YES NO

Kidney or bladder stones........................YES NO

Bedwetting or daytime wetting of clothes.....YES NO

Skin problems in genital or groin area.........YES NO

Problems getting or keeping erections.........YES NO

History of sexually transmitted disease........YES NO

Other (please list)....._______________________

************Fill out below only if you are over 40 years of age or older**************

HISTORY OF PRESENT CONDITION

	Circle your score for each below					
	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
• Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
• Over the past month, how often have had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
• Over the past month, how often have you found you stopped started again several times when you urinated?	0	1	2	3	4	5
• Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
• Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
• Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5+ Times
• Over the past month, how many times did you typically get up to urinate from the time you went to bed until the time you got up?	0	1	2	3	4	5