

PATIENT REGISTRATION

ARKANSAS UROLOGY, P.A.

ACCT.# _____

CLINIC LOCATION _____

Date _____ Appt. Time _____

Pharmacy _____

Today's appt. is with Dr. _____

Pharmacy phone _____

PATIENT INFORMATION

Name _____ Sex _____ Age _____ Date of Birth _____
Last First M.I.

Mailing Address _____ Social Security _____

Physical Address _____ Patient Place of Employment _____

Home Phone _____ Work Phone _____

Pager # _____ Cell Phone _____ Spouse/Parent Name _____

E-Mail _____ Spouse/Parent Work # _____

Name and phone # next of kin not living with you _____

PERSON RESPONSIBLE FOR BILL

Name _____ Home Phone _____ Work Phone _____
Last First M.I.

Address _____ Relation to Patient _____

OTHER INFORMATION

Who referred you to this clinic? Doctor _____ Specialty _____ City _____

Family Member Friend Name _____ Yellow Pages Advertisement Referral Service

Have you ever seen any of our doctors *as a patient* before? _____ In Office _____ In Hosp. _____

Allergies _____ Latex Allergy: Yes No

Reason for Visit _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Phone () _____

Address to mail claims _____

Policy # _____ Group # _____ Program # _____

Policyholder Name _____ Address _____

Policyholder Phone _____ Policyholder Birthdate _____ Sex _____

Policyholder Employer/School _____

Policyholder Relationship to Patient _____ Policyholder SSN _____

Does your primary insurance require Pre-Authorization/Pre-certification? Yes No

Are referrals from primary care physician required? Yes No Primary Physician's Name _____

Secondary Insurance Carrier _____ Phone () _____

Address to mail claims _____

Policy # _____ Group # _____ Program # _____

Policyholder Name _____ Address _____

Policyholder Phone _____ Policyholder Birthdate _____ Sex _____

Policyholder Employer/School _____

Policyholder Relationship to Patient _____ Policyholder SSN _____

Is this policy: A. Medicare Supplemental Policy or B. Employer Sponsored Do you have papers from attorney / Work. Comp? Yes No

MEDICAL RELEASE INFORMATION

I Authorize the release of any medical information necessary to process insurance claims for services and/or supplies provided by Arkansas Urology, P.A.

PAYMENT OF BENEFITS

I Authorize payment of medical benefits to Arkansas Urology for services and/or supplies provided by them.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I Understand and agree that, (regardless status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

X _____

Date _____

Please fill in dots completely.

Social Security Number

____/____/____

correct

incorrect

MALE VOIDING SYMPTOMS

TAKING THE QUIZ

Darken the circle that best represents your response to each of the following questions. The question is designed to gauge the severity of any symptoms you may be experiencing.

	Not at All	Less than 1 time in 5	Less than half of the time	About half of the time	More than half of the time	Almost always	Patient score
1) INCOMPLETE EMPTYING Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?	0	1	2	3	4	5	_____
2) FREQUENCY Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	0	0	0	0	0	0	_____
3) INTERMITTENCY Over the past month, how often have you found you stopped and started again several times when you urinated?	0	0	0	0	0	0	_____
4) URGENCY Over the past month, how often have you found it difficult to postpone urination?	0	0	0	0	0	0	_____
5) WEAK STREAM Over the past month, how often have you had a weak urinary stream?	0	0	0	0	0	0	_____
6) STRAINING Over the past month, how often have you had to push or strain to begin urination?	0	0	0	0	0	0	_____
7) NOCTURIA Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	0	0	0	0	0	_____

YOUR TOTAL SCORE

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
QUALITY OF LIFE TO URINARY SYMPTOMS If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6
	0	0	0	0	0	0	0

YES NO

Do you snore?

Does it ever wake you up?

Social Security Number

____/____/____

REVIEW OF SYSTEMS (MALE)

Do you now or have you had any problems related to the following symptoms? Darken the circle Y (yes) when the symptom is present or N (no) when not present. *Please mark yes or no for each choice.*

<p>GENITOURINARY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Burning with urination</p> <p><input type="radio"/> <input type="radio"/> Blood in urine</p> <p><input type="radio"/> <input type="radio"/> Leakage of urine</p> <p><input type="radio"/> <input type="radio"/> Nighttime voiding: ____ times a night</p> <p><input type="radio"/> <input type="radio"/> Erectile dysfunction</p> <p><input type="radio"/> <input type="radio"/> Flank pain <input type="radio"/> Left side? <input type="radio"/> Right side?</p> <p><input type="radio"/> <input type="radio"/> Scrotal (sack) Pain <input type="radio"/> Left side? <input type="radio"/> Right side?</p>	<p>INTEGUMENTARY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Skin Rash</p> <p><input type="radio"/> <input type="radio"/> Boils</p> <p><input type="radio"/> <input type="radio"/> Varicose Veins</p> <p><input type="radio"/> <input type="radio"/> Enlarged breast</p> <p><input type="radio"/> <input type="radio"/> Painful breast</p>
<p>CONSTITUTIONAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Fever</p> <p><input type="radio"/> <input type="radio"/> Chills</p> <p><input type="radio"/> <input type="radio"/> Headaches</p> <p><input type="radio"/> <input type="radio"/> Unexplained weight loss</p>	<p>NEUROLOGICAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Tremors</p> <p><input type="radio"/> <input type="radio"/> Dizzy Spells</p> <p><input type="radio"/> <input type="radio"/> Numbness/Tingling</p>
<p>EYES</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Impaired Vision</p> <p><input type="radio"/> <input type="radio"/> Pain in eyes</p>	<p>PSYCHIATRIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Do You Have a Depressed Mood?</p> <p><input type="radio"/> <input type="radio"/> Are You Overly Anxious?</p>
<p>EARS, NOSE, MOUTH, THROAT</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Ear Infection</p> <p><input type="radio"/> <input type="radio"/> Sore Throat</p> <p><input type="radio"/> <input type="radio"/> Sinus Problems</p>	<p>ENDOCRINE</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Excessive Thirst</p> <p><input type="radio"/> <input type="radio"/> Too Hot / Cold</p> <p><input type="radio"/> <input type="radio"/> Tired / Sluggish</p> <p><input type="radio"/> <input type="radio"/> Diminished Sexual Drive</p> <p><input type="radio"/> <input type="radio"/> Decreased Muscle Size or Strength</p> <p><input type="radio"/> <input type="radio"/> Problems With Erection</p>
<p>CARDIOVASCULAR</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Chest Pain</p> <p><input type="radio"/> <input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> <input type="radio"/> Swelling in Extremities</p>	<p>HEMATOLOGIC / LYMPHATIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Swollen Glands</p> <p><input type="radio"/> <input type="radio"/> Blood Clotting Problems</p>
<p>RESPIRATORY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Wheezing</p> <p><input type="radio"/> <input type="radio"/> Frequent Coughing</p> <p><input type="radio"/> <input type="radio"/> Shortness of Breath</p>	<p>ALLERGIC / IMMUNOLOGIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Hay Fever</p> <p><input type="radio"/> <input type="radio"/> Drug Allergies</p>
<p>GASTROINTESTINAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Abdominal Pain</p> <p><input type="radio"/> <input type="radio"/> Nausea / Vomiting</p> <p><input type="radio"/> <input type="radio"/> Diarrhea or Loose Stool</p> <p><input type="radio"/> <input type="radio"/> Blood in Stool</p>	<p>Physician Use Only: (Comments / Notes)</p> <hr/> <hr/> <hr/>
<p>MUSCULOSKELETAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Chronic Neck Pain</p> <p><input type="radio"/> <input type="radio"/> Chronic Back Pain</p> <p><input type="radio"/> <input type="radio"/> Pain that Radiates Down Leg Which side? <input type="radio"/> Right? <input type="radio"/> Left? <input type="radio"/> Both?</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p>	

Social Security Number

____/____/____

PAST MEDICAL HISTORY

Section 1

Do you now or have you had the following illnesses? Fill in the circle (Yes or No) and please Give the approximate date when requested. Please mark yes or no for each choice.

Y N Urinary tract problem -----> 1) What type? _____ When? _____
2) What type? _____ When? _____
Bleeding -----> What type? _____ When? _____
Cancer-----> 1) What type? _____ When? _____
2) What type? _____ When? _____
Hepatitis-----> What type? _____ When? _____
Stroke-----> When? _____
Heart Attack (MI) -----> When? _____
Heart Disease
Heart Failure
Irregular Heartbeat
High Blood Pressure
Diabetes
HIV
Emphysema
Pneumonia -----> When? _____
Asthma
Anemia
Seizure
Kidney Stones
Kidney Disease -----> What type? _____
Gout
Glaucoma
Thyroid Disease
Arthritis
Ulcer
Blood Disorder -----> What type? _____
Sickle Cell
Mental Illness / Condition -----> What type? _____
Neurological Condition -----> What type? _____
Gallstones
Gastroesophageal reflux ("GERD")
History of trauma / injury to the penis, testicles, or in this area. If "yes", what? _____

Other Serious Illnesses, Injuries or Treatments: _____

PAST SURGICAL HISTORY: Fill in the appropriate circle and give date.

PROSTATE SURGERY Y N
O O
If "yes", what type? When? _____
O O Transurethral (through scope, no scar)
O O Abdominal (scar lower abdomen)

VASECTOMY O O When? _____

Social Security Number

____/____/____

MEDICATIONS – Do you take any medications? (Include aspirin and vitamin supplements)

Yes No

If yes, please list:

Medication	Dosage or Amount
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Note: If you need more space, please ask for an additional medication sheet.

Do you take?

Y N

Blood Thinner? (e.g. Aspirin, Coumadin, Plavix) What Type(s)? _____

ALLERGIES:

Y N

Please list medication to which you are allergic:

Type of Reaction(s):

Nausea Rash Swelling Breathing Problems Other (Describe)

	Nausea	Rash	Swelling	Breathing Problems	Other (Describe)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Note: If you need to list more allergies, please ask for an additional allergy sheet.

Y N

Are you allergic to x-ray dye? What type of reaction? _____
 Are you allergic to iodine or seafood? What type of reaction? _____
 Are you allergic to latex? What type of reaction? _____

SECTION II

FAMILY HISTORY:

If the answer to any of these questions is yes, please tell which relative.

Do you have a family history of

Y N

Prostate cancer? Relative? _____
 Cancer of the kidneys, ureters, bladder, penis, testicles or any other part of the urinary tract? Relative? _____ Type? _____
 Urinary tract infections? Relative? _____
 Kidney stones? Relative? _____ Type? _____
 Kidney disease? Relative? _____
 Hematuria/blood in urine? Relative? _____

