

Patient Information

Please answer all questions fully

Date: _____

Account Number: _____

THE UROLOGY CENTER OF CHESTER COUNTY, P.C.

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 West Chester, PA 19380
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 (610) 383-7663 • Fax: (610) 383-6377

PATIENT						
Name (Last, First, MI)		Social Security		Birthdate	Sex	Home Phone
Mailing Address		City	State	Zip	Marital Status	
Employer		City	State	Zip	Work Phone	
RESPONSIBLE PARTY						
Name (Last, First, MI)		Social Security		Birthdate	Sex	Home Phone
Mailing Address		City	State	Zip	Marital Status	
Employer		City	State	Zip	Work Phone	
PRIMARY PHYSICIAN			REFERRING PHYSICIAN			
INSURANCE INFORMATION						
Primary Insurance Company	Subscriber's Name		Relationship	Policy Number	Group #	
Second Insurance Company	Subscriber's Name		Relationship	Policy Number	Group #	
Third Insurance Company	Subscriber's Name		Relationship	Policy Number	Group #	
EMERGENCY CONTACT INFORMATION						
Contact Name		Relationship	Primary Phone Number	Secondary Phone Number		
PLEASE LIST ALL PRESENT MEDICATIONS, AND ANY KNOWN ALLERGIES:						

PATIENT RELEASE:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

SIGNATURE: _____ DATE: _____

(SIGNATURE OF INSURED OR AUTHORIZED PERSON, PATIENT OR PARENT IF MINOR)

THE UROLOGY CENTER OF CHESTER COUNTY, P.C.

NEW PATIENT QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Referring Doctor: _____

What is the main reason that you are seeing the doctor today?

PAST MEDICAL HISTORY:

Illnesses: (List any medical conditions you have such as High Blood Pressure, Diabetes, Heart Disease, High Cholesterol, etc...)

Surgeries: (List any operations you have had and approximately when they were done.)

Medications: (List all medications you take including dosages if possible.)

Allergies: (List all allergies to Medications, Anesthetics, Contrast agents, etc...)

Occupation: _____

Marital Status: _____

Ages and Sex of Children: _____

Cigarettes: (Packs per day) _____

Alcoholic Beverages: (Drinks per day) _____

Family History: List your parents' age and medical condition if living. If parents deceased, list age and cause of death.

Father _____

Mother _____

Is there a family history of?:

- | | | |
|--------------------|------------------------------|-----------------------------|
| Prostate Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bladder Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Stones | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

REVIEW OF SYSTEMS

Do you have any problems now or have you had any related to the following systems? Please check Yes (Y) or No (N)

Constitutional Symptoms Weight change <input type="checkbox"/> Y <input type="checkbox"/> N Chills <input type="checkbox"/> Y <input type="checkbox"/> N Fever <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Genitourinary Change in stream <input type="checkbox"/> Y <input type="checkbox"/> N Nocturia (getting up at night) <input type="checkbox"/> Y <input type="checkbox"/> N Urinary frequency >8 times/day <input type="checkbox"/> Y <input type="checkbox"/> N Burning with urination <input type="checkbox"/> Y <input type="checkbox"/> N Other:
Eyes Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N Cataracts <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Musculoskeletal Muscle weakness <input type="checkbox"/> Y <input type="checkbox"/> N Joint pain (swelling) <input type="checkbox"/> Y <input type="checkbox"/> N Other:
Cardiovascular Chest pain <input type="checkbox"/> Y <input type="checkbox"/> N Irregular heartbeat <input type="checkbox"/> Y <input type="checkbox"/> N Swelling in ankles <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Neurological Tremors <input type="checkbox"/> Y <input type="checkbox"/> N Dizzy spells <input type="checkbox"/> Y <input type="checkbox"/> N Numbness/tingling <input type="checkbox"/> Y <input type="checkbox"/> N Stroke <input type="checkbox"/> Y <input type="checkbox"/> N
Psychologic Do you feel depressed? <input type="checkbox"/> Y <input type="checkbox"/> N Do you feel anxious? <input type="checkbox"/> Y <input type="checkbox"/> N	Respiratory Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N Frequent cough <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> N Other:
Endocrine Excessive thirst <input type="checkbox"/> Y <input type="checkbox"/> N Too hot/cold <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Gastrointestinal Abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> N Nausea/vomiting <input type="checkbox"/> Y <input type="checkbox"/> N Indigestion/heartburn <input type="checkbox"/> Y <input type="checkbox"/> N Constipation/diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N
Hematologic/Lymphatic Swollen glands <input type="checkbox"/> Y <input type="checkbox"/> N Blood clotting problem <input type="checkbox"/> Y <input type="checkbox"/> N Bruising <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Sexual History Change in sex drive? <input type="checkbox"/> Y <input type="checkbox"/> N Sexual performance satisfactory? <input type="checkbox"/> Y <input type="checkbox"/> N Other:

Male Only	AUA Symptom Score: Circle one number in each line						
<i>Questions to be answered</i>	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	
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5	
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5	
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5	
Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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
Sum the seven circled numbers (AUA Symptom Score):	Scoring: Mild 0 - 7		Moderate 8 - 19		Severe 20 - 35		

Physician Signature: _____ Date: _____