Advanced Urology
Patient-centered care for your most sensitive problems

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Welcome to Advanced Urology!

Once you have an appointment with us, we will send you a New Patient packet via US Mail or Email. You can also download the forms via our website.

We utilize electronic medical records and will be able to set you up on your own PATIENT PORTAL when you arrive. Please come about 15 minutes prior to your appointment time to finish up any paperwork and register in our system.

To provide you the best attention and treatment, please bring the following with you on your first visit:

~ Your completed initial patient packet
~ Your driver's license, or other government issued photo I.D.
~ All medical Insurance cards
~ Pharmacy information, local or mail order
~ Any laboratory work including previous urinalysis, cultures, PSA blood tests.
~ Any relevant, imaging reports, and especially CD's such as ultrasounds, CT scans and MRI's
~ Current medication listing with correct spelling and dosage information

We look forward to meeting you and providing you with excellent Urology care.

Westchester
8540 S. Sepulveda Blvd Suite 911
Los Angeles, CA 90045

Redondo Beach
510 N. Prospect Suite 115
Redondo Beach, CA 90277

Culver City
9808 Venice Blvd Suite 602
Culver City, CA 90230

Website: WWW.AdvancedUrology.Net | Phone number: 310.670.9119

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Patient Information

First _____ MI _____ Last _____ DOB _____

Address _____ Apt _____ City _____

State _____ Zip _____

Social Security Number _____ Sex: ☐ Male ☐ Female

>>>>>Please circle which number below we can leave a confidential medical message <<<<<

Main _____ Cell _____ E-Mail Address_____

MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse name _____

Employer _____ Occupation _____

Primary Doctor _____ Phone # _____

>>>>>>> Referred By _____ Phone # _____ <<<<<<<

Insurance Information (check one)

☐ PPO ☐ HMO ☐ SELF PAY ☐ MEDICARE/MEDICAL

PRIMARY INSURANCE _____ Policy Holder Name _____

☐ Self ☐ Spouse ☐ Parent Policy Holder Date of Birth _____

Please confirm sign and date below

Sign _____ Date _____

If other than Patient, please print name : _____ Relationship to Patient _____

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Patient Name: _____

Date of Birth: _____

Medical History

Reason for today's visit: _____

Current Medications: List all medications you are currently take including vitamins, herbal supplements, and over the counter medications.

Medication	Dosage	Medication	Dosage

Allergies:

_____

Preferred Pharmacy:

Name	Address

Past Surgical History:

Type of Surgery	Year

Recent Hospitalizations:

Dates	Reason	Hospital

Personal Medical History (check all that apply to you)

☐ Anemia ☐ Asthma, Emphysema ☐ Bladder, Kidney infections ☐ Bleeding Disorder ☐ Blood Clots
☐ Blood in Urine/Stool ☐ Cancer ☐ Diabetes ☐ Erection Problems ☐ Gastrointestinal ☐ Heart Disease
☐ Hepatitis ☐ High Blood Pressure ☐ Incontinence ☐ Kidney Stones ☐ Pregnancies ☐ Prostate Cancer
☐ Stroke ☐ Urination problems

Other problems: _____

_____

Vaccinations

Flu ☐ Yes ☐ No Pneumococcal ☐ Yes ☐ No

Vitals

Ht: _____ Wt: _____ BP: _____ Temp: _____ PVR: _____

Patient Name: _____

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History of Tobacco Use:

___ Current Smoker ___ Former Smoker ___ Never Smoked

History of Alcohol Use:

___ Daily ___ Occasional ___ Former ___ Never

Family Medical History:

	Father	Mother	Brother	Sister
Alive	☐	☐	☐	☐
Cause of Death	_____	_____	_____	_____
COPD	☐	☐	☐	☐
CVA/TIA	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Myocardial Infarction	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐
Stones	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Other	_____	_____	_____	_____

ROS

	Yes	No
Constitutional		
Fever	☐	☐
Cardiovascular		
Chest Pain	☐	☐
Hematologic		
Easy Bruising	☐	☐
Genitourinary		
Leak Urine/Wet Self	☐	☐
Respiratory		
Shortness of Breath	☐	☐
Gastrointestinal		
Constipation	☐	☐
Neurological		
Decreased Sensation	☐	☐
Pain		
Are you experiencing pain?	☐	☐
ENTM		
Hearing Loss	☐	☐
Musculoskeletal		
New Bone Pain	☐	☐
Immunologic		
Latex Allergy	☐	☐
Colonoscopy	☐	☐

Are You Experiencing Any Other Symptoms Today? _____

_____

_____

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AUMO Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices which provides information about how we may use and disclose Protected Health Information (PHI) about you. The notice details your rights under the law. You have the right to review our Notice before signing this Acknowledgment. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or from our website.

Please check the first box below and sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of that Advanced Urology Medical Offices notice of Privacy Practices.

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the patient, but it could not be obtained because: _____

We cannot discuss your PHI with anyone other than yourself unless you authorize us to do so except for necessary instances allowing for disclosure as explained in our Notice of Privacy Practices. Please list below name(s) of the individual(s) (family, friends, etc.) with whom we may discuss your care. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

	Name	Relationship to Patient	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

_____ _____
Name of Patient (print) Date of Birth

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Date
(Required if patient is a minor or an adult who is unable to sign this form)

_____ _____
Relationship of Patient Representative to Patient Print Name

Bladder Satisfaction Survey

Name:_____ DOB:_____ Date:_____

Which symptoms best describe you?

☐ Frequent Urination- Day, Night or Both ☐ Leaking with Sneezing, Coughing, Exercising

☐ Sudden or Strong Urge to urinate ☐ Leaking with Urge or No Warning

☐ Unable to Empty the Bladder ☐ Bladder or Pelvic Pain

How long have you had these symptoms: _____

Have you tried medications to help your symptoms? ☐ Yes ☐ No

If yes, circle the medications you have tried:

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

Did these medications help your symptoms? Circle #: No Relief-0 1 2 3 4 5 6 7 8 9 10-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, kegels, lifestyle changes, bladder training, pelvic floor muscle training)

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

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

Are you interested in learning more about treatment alternatives to medications?

☐ Yes ☐ No