COVID-19

Patient Wellness Questionaire

1. Have you recently traveled out of the Country or to an area with known local spread of COVID-19?

   Y__ N___

2. Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID – 19 diagnosis in the past 14 days?

   Y___ N___

3. Do you have a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, chills, body-ache, vomiting, shortness of breath, difficulty breathing or sore throat?

   Y___ N___

Print Name: _____

Patient signature: _____

Tel: _____

Date: _____

Oceanside Urology, LLC

Daniel J. Caruso, MD ☐
Kaveh Besharat, MD ☐

Consent for Treatment

Patient's name: _____

I,_____, agree and consent to participate in the medical care offered and provided by Oceanside Urology, LLC. If the patient is under the age of eighteen (18) or unable to consent to treatment, I attest that I have legal custody of the above named individual and I am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual. I further understand that the Doctor may order testing during my appointment. It is my responsibility to make sure that the test gets scheduled and that I follow through with completion of the test. This includes and is not limited to blood work, imaging and biopsy testing. I also understand that it is ultimately my responsibility as the patient to ensure that I receive the results of such testing.

X_____ _____

Signature Date

_____

Relationship to patient

Oceanside Urology, LLC

Daniel J. Caruso, MD ☐
Kaveh Besharat, MD ☐

Please read carefully. Responsible parties whose signatures appear below agree as follows:

The responsible parties agree to pay to Oceanside Urology, LLC, for all fees and charges for supplies, services and treatment that are incurred by the patient. It is the responsibility of the responsible parties to know his/her health benefits. Therefore, responsible parties are strongly advised to monitor and communicate with his/her Health Insurance Company to ensure that Doctor's claims are paid promptly, since they, as responsible parties, are ultimately financially responsible for all amounts owed to Oceanside Urology, LLC. It is important that you know that not all services and/or fees are covered or paid for by the Responsible Parties' Health Insurance Company; therefore, the Responsible Parties agree to pay for all deductibles, copayments, non- covered services, and any portion of covered services not paid in full by the Plan. Depending on the patient's Health Insurance Plan, payments are due at the time of service or immediately upon presentation of the bill. There are no other agreements, promises, representations or warranties, expressed or implied to substitute this agreement.

Agreed to and accepted by the Responsible Parties.

X:_____ _____/_____/_____

Signature Date

_____

Printed Name

221 Greenwich Circle, Suite 107
Jupiter, Florida 33458
Phone: 561-746-9227
Fax: 561-746-9221

OCEANSIDE UROLOGY, LLC

DANIEL J. CARUSO, MD
KAVEH BESHART, MD

PATIENT APPOINTMENT POLICIES

NO SHOW/SAME DAY CANCELLTION POLICY

If you must cancel an appointment, kindly give us at least 24 hours notice. We appreciate how challenging life can be, but no show or same day cancellation will incur a service charge in the amount of $25.00. Also, for a third no show or same day cancellation within a 12-month period there will be a service charge in the amount of **$50.00.** Any additional no shows or same day cancellations may result in dismissal from our practice. This policy also includes surgical cases with a service charge of $200.00.

PATIENT LATE ARRIVAL POLICY

Oceanside Urology, LLC strives to provide the best care possible to our patients. We understand that life can be unpredictable. However, our appointments do fill quickly, and we want to provide all our patients with the best access. If you are an established patient and you arrive 20 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. If they can, you will then be moved to the next available time slot that same day. Priority will be given to the patients that arrive on time and you may have to be worked in between them if you choose to wait although this may mean you will have a considerable wait time.

If this is not convenient for you, you may choose to reschedule. We strive to see every patient as close to their appointment time as possible. If you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed, you may also be asked to reschedule. We advise that you download from Oceanside Urology, LLC website (www.Oceansideurology.net), fill out, print and bring the new patient paperwork completed to your appointment to avoid any unnecessary delays.

Signature: _____ Date: _____

PELVIC EXAMINATIONS CONSENT FORM

Patient Name: _____

Date of Birth: _____

****

- **CONSENT:** I, the above listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examinations being performed by my physician or other health care practitioner at Oceanside Urology LLC. This consent will be good until it is revoked by you (the patient).

- **NATURE OF PELVIC EXAMINATIONS:** For the purposes of this Consent Form, a "pelvic examination" means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, external pelvic tissue, or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

- **VALIDITY OF CONSENT:** The Patient, or the Patient's legally authorized person, acknowledges that this consent will remain valid from the date the Patient, or the Patient's legally authorized person, dated this Consent Form below, unless otherwise revoked in writing by the Patient, or the Patient's legal authorized person.

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____

Patient's Signature Date

_____ _____

Legally Authorized Person Signature Relationship to Patient

_____ _____

Legally Authorized Person Printed Name Date

_____

Witness Signature

_____ _____

Witness Printed Name Date

Daniel J. Caruso, MD

Kaveh Besharat, MD

Demographic Information

Date: ___/___/___

Name: _____ **D.O.B:** ___/___/___

Gender: F___, M___, T___

Address: _____

City: _____, **State:** _____ **ZipCode:** _____

Home Phone: (___) _____-_____ **Cell Phone:** (_____) _____-_____

Can we text you at the cellphone number above? Y____ N____

Social Security: _____-_____-_____

Email Address: _____@_____

Primary Care Doctor: _____

Who referred you to us? _____

Emergency Contact:

Name: _____ **Phone:** _____

Relation: _____

I give this person permission to discuss my health information? Y____ N____

Pharmacy:

Name: _____ **Phone:** _____

Location: _____

MALE

Oceanside Urology, LLC

Daniel J. Caruso, MD ☐
Kaveh Besharat, MD ☐

Patient Name: _____

-INTAKE-

What is the reason for your visit today? (Please describe in detail)

_____
_____
_____

For How Long?_____Degree of Severity: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10☐

-MEDICAL HISTORY-

If none of this applies, please do not leave blank. Please write N/A.

PAST MEDICAL HISTORY

_____
_____
_____
_____
_____
_____
_____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____
_____

UROLOGIC HISTORY

Yes	No	
☐	☐	Prostate biopsy/surgery
☐	☐	Elevated PSA
☐	☐	Prostate cancer
☐	☐	Kidney stones
☐	☐	Kidney/Bladder cancer

MEDICATION ALLERGIES (including iodine)

_____
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY

_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

☐Yes ☐no Family hx of prostate cancer?

_____
_____
_____

SOCIAL HISTORY

Do you smoke: _____
How many packs per day? _____
How many years? _____
When did you quit? _____
Do you drink alcohol? _____
How many drinks per week? _____
When did you quit? _____
Do you use any illicit drugs? _____

221 Greenwich Circle, Suite 107
Jupiter, Florida 33458
Phone: 561-746-9227
Fax: 561-746-9221

MALE

Oceanside Urology, LLC

Daniel J. Caruso, MD ☐
Kaveh Besharat, MD ☐

- Review of Systems-

Yes	No	**Constitutional**
☐	☐	Unwanted weight loss
☐	☐	Fever (last 72 hours)
☐	☐	Chills (last 72 hours)

Yes	No	**HEENT**
☐	☐	Change in vision
☐	☐	Problems swallowing
☐	☐	Glaucoma

Yes	No	**Cardiovascular**
☐	☐	History of blood clots
☐	☐	Chest pain (last 72 hours)
☐	☐	Palpitations (last 72 hours)
☐	☐	Dizziness (last 72 hours)

Yes	No	**Endocrine**
☐	☐	Excessive thirst
☐	☐	Heat/cold intolerance
☐	☐	Hot Flashes

Yes	No	**Respiratory**
☐	☐	Frequent cough
☐	☐	Short of breath (last 72 hours)
☐	☐	Wheezing (last 72 hours)

Yes	No	**Gastrointestinal**
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Rectal bleeding

Yes	No	**Psychiatric**
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Suicidal ideation

Yes	No	**Genitourinary**
☐	☐	Pain while urinating
☐	☐	Burning while urinating
☐	☐	Blood in urine
☐	☐	Hesitancy in going
☐	☐	Incontinence
☐	☐	Retention of urine
☐	☐	Difficulty with erections
☐	☐	Pain with intercourse
☐	☐	Weak urinary stream
☐	☐	Strain to urinate
☐	☐	Bladder/kidney infections
☐	☐	Frequency of urination

Yes	No	**Musculoskeletal**
☐	☐	Joint pain
☐	☐	Neck pain
☐	☐	Back pain

Yes	No	**Neurological**
☐	☐	Strokes
☐	☐	Seizures
☐	☐	Tremors

Yes	No	**Skin**
☐	☐	Rashes
☐	☐	Jaundice
☐	☐	Boils

Height:_____(ft)_____(in)
Weight:_____(lbs)

221 Greenwich Circle, Suite 107
Jupiter, Florida 33458
Phone: 561-746-9227
Fax: 561-746-9221

International Prostate Symptom Score (IPSS)

Patient Name: _____ Today's Date: _____

Daytime Phone Number: _____ Date of Birth: _____

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – 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?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = _____

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

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

	Yes	No
Have you tried medications to help your symptoms?		

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

	Yes	No
Would you like to discuss a minimally invasive procedure to treat your bothersome urinary symptoms with your doctor?		

The information provided in this form may be de-identified and aggregated and provided to a 3rd party for use.