PRINCE WILLIAM UROLOGY ASSOCIATES
PATIENT REGISTRATION

Patient Name: _____
Last First Middle

Address: _____
Street State Zip

Date of Birth: ____/____/____ Social Security: ____-____ -____ Email: _____

Home phone: _____ Cell: _____ Work: _____

Pharmacy: _____

Sex: M___ F____ Marital Status: S__ M__ D__ W__

Race: ___Asian ___ Native Hawaiian ___ Other Pacific Islander ___ African American ___ American ___Indian/Alaska Native ___ Caucasian ___ Hispanic ___ More than one Race ___ Refuse to Report

Preferred Language: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Referred by: _____Phone Number: _____

Family Physician Name: _____ Phone Number: _____

<u>Insurance information</u>
Primary Insurance: _____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ Date of Birth: ___/____/___ Relationship: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Name of Policy Holder: _____ Date of Birth: ___/____/___ Relationship: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay all fees immediately upon completion of all services unless other arrangements are made in advance.

Patient/Guardian Signature: _____ Today's Date: _____

PRINCE WILLIAM UROLOGY

8525 Rolling Road, Suite 220
Manassas, VA 20110
Tel: 703-393-0700
Facsimile: 703-393-0661

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral.

I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Printed Patient Name (and Guardian Name if applicable) Patient or Guardian Signature

Patient Date of Birth _____ Date _____

Our office does not make the rules. They are determined by your specific medical insurance or vision plan.

PRINCE WILLIAM UROLOGY
Andrew K. Chung, MD
Anshu Guleria MD, FACS
Ali Sajadi, MD
Katie Riley, PA-C

LAB SPECIMEN CONSENT

Prince William Urology recommends several lab testings that will require shipment to outside labs. Listed below are some of the lab test that must be done with the purposes of determining appropriate treatment plans.

- **Prostate biopsy**
- **Bladder biopsy**
- **Vasectomy specimen**
- **Urine culture**
- **Urine cytology**
- **Urine FISH**
- **Urine DNA culture**
- **Kidney/Bladder Stone Analysis**
- **Serum lab tests (PSA, testosterone, chem 7, CBC, vitamin D level, AFP, HCG, LH, FSH levels)**

- I acknowledge that Prince William Urology is unable to determine any out of pocket costs associated with these labs.
- I acknowledge that my insurance could make me responsible for in or out of network deductibles, coinsurance and or copay costs associated with these labs.

Feel free to contact our office Manager with any billing questions or concerns.

Patients Name:_____**DOB:** _____

Signature:_____ **Date:** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

PRINCE WILLIAM UROLOGY ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Anshu Guleria, MD- Katie Riley- PA-C

New Patient Urologic History Form - Men

Patient's Name: _____
(Last) (First) (MI) (Date)

Age: _____ DOB: _____ Height _____ Weight _____

Referring Dr: _____ Primary Dr:_____

What is the ***main reason*** for your visit today? Write in your own words on the lines provided:

_____

_____

When did you first notice the problem? _____

Location of the problem? (if applicable) _____

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 N/A

How long does the problem last? _____Is the problem: ☐ Constant ☐ Variable ☐ Seldom

Does anything make the problem worse? _____ If yes, what makes it worse? _____

Does anything make the problem better? _____ If yes, what makes it better? _____

Does the problem interfere with your normal activities? ☐ Yes ☐ No

What testing have you had to evaluate your urological problem?

☐ I have had no tests to evaluate this problem

☐ X-ray	☐ Ultrasound	☐ Urodynamic Testing
☐ CT scan	☐ Nuclear bone scan	☐ Other: _____
☐ MRI	☐ Nuclear renal scan	☐ Unsure
☐ IVP	☐ Urine specimen	
☐ Blood tests	☐ Cystoscopy	

Where was the test performed? _____

8525 Rolling Rd, Suite 220 Manassas, VA 20110-3648
Phone: (703) 393-0700; Fax: 703-393-0661

PRINCE WILLIAM UROLOGY ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Anshu Guleria, MD- Katie Riley- PA-C

Do you leak urine? ☐ Yes ☐ No

Is your leakage associated with the urge to urinate? ☐ Yes ☐ No

Is your leakage associated with coughing, laughing, jumping, sneezing, or exercising? ☐ Yes ☐ No

Do you wear protective pads? ☐ Yes ☐ No If so, how many? _____

Do you have a problem with libido/desire? ☐ Yes ☐ No

Do you have a problem achieving or maintaining an erection? ☐ Yes ☐ No

Have you tried any medications for erectile dysfunction? ☐ Yes ☐ No

If yes, please indicate which medication(s) below:
☐ Viagra ☐ Cialis ☐ Levitra ☐ Staxyn ☐ MUSE ☐ Injection therapy ☐ Other:_____

Would you like to discuss erectile function with your doctor today? _____ (Note: an additional appointment may be required if this is not your primary problem)

Are there any other urologic issues you would like to discuss with Dr. _____today? ☐ Yes ☐ No

(Please explain:) _____

Allergies: Are you allergic to:

☐ Latex	☐ Iodine/Betadine	☐ Penicillin
☐ Dye/IV Contrast	☐ Tape/Adhesives	☐ Sulfa
☐ Shellfish/Shrimp!	☐ Anesthetics	☐ Cipro/Levaquin

☐ I have no medication allergies

Medication allergies: (List all)

Medications:
Do you take any medications? ☐ Yes ☐ No

Are you currently taking the following blood thinners? ☐ Aspirin ☐ 81 mg or ☐ 325 mg
☐ Motrin ☐ Aleve ☐ Ibuprofen ☐ Celebrex ☐ Mobic ☐ Other: _____
☐ Coumadin ☐ Warfarin ☐ Plavix ☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Heparin ☐ Lovenox

8525 Rolling Rd, Suite 220 Manassas, VA 20110-3648
Phone: (703) 393-0700; Fax: 703-393-0661

PRINCE WILLIAM UROLOGY ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Anshu Guleria, MD- Katie Riley- PA-C

Please list all the medications you take with the dosage and frequency:

Medication	***Dose***	***How Often***

Please list all Vitamins & Supplements such as Vitamin E, Fish oil, Herbal preparation, Garlic, etc:

Past & Present Medical Problems

- ☐ Irregular heartbeat
- ☐ Carotid artery disease
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Peripheral vascular
- ☐ Heart valvular disease
- ☐ Renal artery stenosis
- ☐ Heart disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Sarcoidosis
- ☐ Sleep apnea
- ☐ Tuberculosis
- ☐ Cirrhosis
- ☐ Crohn's disease
- ☐ Heartburn/GERD
- ☐ Diverticulosis
- ☐ Kidney failure
- ☐ Endometriosis
- ☐ Polycystic kidney disease
- ☐ Kidney stones
- ☐ Vesicoureteral reflux
- ☐ Kidney infections/UTI
- ☐ Kidney obstruction
- ☐ Enlarged prostate/BPH
- ☐ Prostate infection
- ☐ STD's
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Polio
- ☐ Artificial joints
- ☐ Lupus
- ☐ Addison's Disease
- ☐ Cushing's disease
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Multiple sclerosis
- ☐ Myasthenia gravis
- ☐ Parkinson disease
- ☐ Seizures
- ☐ TIA
- ☐ Anemia
- ☐ Sickle cell anemia
- ☐ Blood clots
- ☐ HIV/AIDS
- ☐ Glaucoma
- ☐ Drug dependency
- ☐ Depression
- ☐ Bladder cancer
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Kidney cancer
- ☐ Lung cancer
- ☐ Penile cancer
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Testicular cancer

8525 Rolling Rd, Suite 220 Manassas, VA 20110-3648
Phone: (703) 393-0700; Fax: 703-393-0661

☐ Hepatitis B	☐ Hypothyroidism	☐ Uterine cancer
☐ Hepatitis C	☐ Alzheimer's	☐ Cancer, Other:
☐ Irritable bowel	☐ Bipolar	☐ Other:_____
☐ Peptic ulcer disease	☐ Stroke	_____
☐ Ulcerative colitis	☐ Dementia	_____

Surgical History

Date	Surgery	Date	Surgery

Family History (please indicate which family member)

☐ Urinary infections	☐ Kidney stones	☐ Prostate cancer
☐ Bleeding disorders	☐ Diabetes	☐ Kidney cancer
☐ Heart disease	☐ Bladder cancer	☐ Other:_____

Tobacco/ Alcohol History

Do you currently smoke? ☐ Yes ☐ No How much? _____
Did you smoke in the past? ☐ Yes ☐ No How long? _____ When did you quit? _____
Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____
Do you use recreational drugs? ☐ Yes ☐ No Substances: _____

Thank you for taking the time to complete your urological health questionnaire. Welcome to our practice! Prince William Urology Associates, Ltd.

PRINCE WILLIAM UROLOGY ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Anshu Guleria, MD- Katie Riley- PA-C

REVIEW OF SYSTEMS

Name: _____ **Date:** _____

Please ☑ check only the problems that **currently** apply to you

CONSTITUTIONAL

☐ Fever
☐ Chills
☐ Weight gain
☐ Weight loss

EYES

☐ Blurred vision
☐ Vision loss

EARS/ NOSE/ THROAT

☐ Hearing loss
☐ Sinus problems
☐ Difficulty swallowing
☐ Sore throat
☐ Dental problems
☐ Nose bleeds

CARDIOVASCULAR

☐ Chest pain
☐ Palpitations
☐ Irregular heartbeat
☐ Swelling of feet/ Extremities

RESPIRATORY

☐ Shortness of breath
☐ Chronic cough
☐ Coughing up blood

GASTROINTESTINAL

☐ Poor appetite
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Abdominal pain
☐ Blood in stool
☐ Heartburn

GENITOURINARY

☐ Blood in urine
☐ Easy bruising
☐ Leakage of urine
☐ Weak stream
☐ Frequency urination
☐ Urge to void suddenly
☐ Getting up at night to Urinate
☐ Problems with erection
☐ Pain with intercourse
☐ Bladder pain
☐ Pelvic pain
☐ Burning with urination
☐ Frequent urine infections

MUSCULOSKELETAL

☐ Back pain
☐ Joint pain
☐ Muscle aches

INTEGUMENTARY/SKIN

☐ Rash
☐ Atypical moles
☐ Itchy skin

NEUROLOGIC

☐ Numbness
☐ Weakness
☐ Dizziness

HEMATOLOGIC/ LYMPHATIC

☐ Bleeding tendency
☐ Swollen lymph gland

ENDOCRINE

☐ Excessive thirst
☐ Hot/cold Intolerance
☐ Hormone problem
☐ Fatigue

ALLERGY

☐ Medication allergy
☐ Latex allergy
☐ Seasonal allergy

PSYCHIATRIC

☐ Depression
☐ Anxiety

****Healthcare provider only:** The above systems have been reviewed by: _____
Physician's initials

8525 Rolling Rd, Suite 220 Manassas, VA 20110-3648
Phone: (703) 393-0700; Fax: 703-393-0661

International Prostate Symptom Score (I-PSS)

Patient Name: _____ Date of birth: _____ Date completed _____

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

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 just the way it is now, how would you feel about that?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

About the I-PSS

The International Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms and one question concerning quality of life. Each question concerning urinary symptoms allows the patient to choose one out of six answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

The questions refer to the following urinary symptoms:

Questions	Symptom
1	Incomplete emptying
2	Frequency
3	Intermittency
4	Urgency
5	Weak Stream
6	Straining
7	Nocturia

Question eight refers to the patient's perceived quality of life.

The first seven questions of the I-PSS are identical to the questions appearing on the American Urological Association (AUA) Symptom Index which currently categorizes symptoms as follows:

Mild (symptom score less than of equal to 7)
Moderate (symptom score range 8-19)
Severe (symptom score range 20-35)

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), recommends the use of only a single question to assess the quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of benign prostatic hyperplasia (BPH) Symptoms or quality of life, it may serve as a valuable starting point for a doctor-patient conversation.

The SCI has agreed to use the symptom index for BPH, which has been developed by the AUA Measurement Committee, as the official worldwide symptoms assessment tool for patients suffering from prostatism.

The SCI recommends that physicians consider the following components for a basic diagnostic workup: history; physical exam; appropriate labs, such as U/A, creatine, etc.; and DRE or other evaluation to rule out prostate cancer.