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 ASSOCIATES, LTD

Ali M Sajadi, MD - Andrew K Chung, MD - Amy K Moreno, MD - Anshu Guleria, MD

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	

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Where was the test performed? _____

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

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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

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 disease
☐ Heart valvular disease
☐ Renal artery stenosis
☐ Heart disease
☐ Asthma
☐ Bronchitis
☐ COPD
☐ Cystic fibrosis
☐ Pneumonia
☐ Pulmonary embolism

☐ 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

☐ 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

☐ Sarcoidosis	☐ Artificial joints	☐ Kidney cancer
☐ Sleep apnea	☐ Lupus	☐ Lung cancer
☐ Tuberculosis	☐ Addison's Disease	☐ Penile cancer
☐ Cirrhosis	☐ Cushing's disease	☐ Prostate cancer
☐ Crohn's disease	☐ Diabetes	☐ Skin cancer
☐ Heartburn/GERD	☐ Hyperthyroidism	☐ Testicular cancer
☐ Hepatitis B	☐ Hypothyroidism	☐ Uterine cancer
☐ Hepatitis C	☐ Alzheimer's	☐ Cancer, Other:
☐ Irritable bowel syndrome	☐ 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.

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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

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

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

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☐ Palpitations
☐ Irregular heartbeat
☐ Swelling of feet/ Extremities

RESPIRATORY

☐ Shortness of breath
☐ Chronic cough
☐ Coughing up blood

☐ Pelvic pain
☐ Burning with urination
☐ Frequent urine infections

MUSCULOSKELETAL

☐ Back pain
☐ Joint pain
☐ Muscle aches

ALLERGY

☐ Medication allergy
☐ Latex allergy
☐ Seasonal allergy

PSYCHIATRIC

☐ Depression
☐ Anxiety

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

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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: _____