

UROLOGY SPECIALISTS,P.C.

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Date _____



Who may we thank for referring you here? _____

How did you obtain our office phone number? (circle one)

Someone called for me Friend Family

My Doctor made the appointment

Long-Distance Information

Telephone Directory (which one? _____)

Referring Doctor's Name _____

Family Doctor's Name _____

check here if you do NOT want any information sent to your family doctor.

Your cooperation in completing this questionnaire will make your consultation more thorough and efficient!

NAME: _____

PATIENT'S SOC. SEC. # _____

SPOUSE'S NAME: _____

NAME INSURANCE CO.

ADDRESS: _____ street
 _____ city
 _____ state/zip

1. _____
 2. _____
 3. _____

Phone: () - - home

POLICYNUMBER ABOVE INS. COS.:

Phone: () - - work

1. ID # _____

YOUR AGE: _____

2. GRP. # _____

BIRTHDATE: _____

3. POLICYHOLDER S.S. # _____

MARITAL STATUS: _____

MEDICARE NUMBER: _____

RACE: _____

MEDICAID NUMBER: _____

RELIGION: _____

UMW #: _____

CITIZENSHIP: _____

BLUE-CROSS/BLUE SHIELD NO.:

YOUR OCCUPATION: _____

IND. OR ILL. _____

SPOUSE'S OCCUPATION: _____

GRP. # _____

YOUR EMPLOYER: _____

SPOUSE'S EMPLOYER: _____

Assignment of Surgical Medical Benefits

Policy No. _____ Issued to _____

In consideration of the surgical and medical care and service rendered to: _____

PATIENT'S NAME
 by Urology Specialists, P.C. Vincennes, Indiana dating from _____ I hereby assign, transfer and set over to Urology Specialists, P.C., the benefits as may be provided for and due me or which may accrue to me under the terms, conditions and provisions of the above described policy contract. I hereby authorize said Company to pay such sum of money direct to Urology Specialists, P.C.

I agree that should the amount be insufficient to cover my entire surgical and medical expense, I will be responsible for payment of the difference; and that, if my illness be such that it is not covered by the policy contract, I will be responsible to Urology Specialists, P.C., for payment of the entire surgical and medical bill.

Witness my hand this _____ day of _____, Year _____

Policyholder _____

NOTE: All questions that follow will be held in the strictest confidence and will not be available to anyone without your permission!

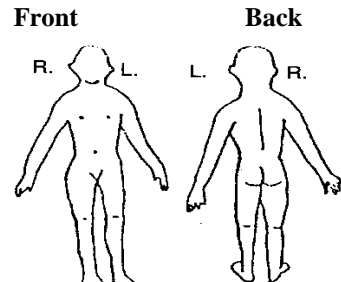
In your own words . . .

THE MAIN CONCERN FOR WHICH THE PATIENT IS HERE TODAY:

HISTORY OF PRESENT ILLNESS Please answer the following questions.

Location of the problem:

Abdomen Back Leg
 Other _____



ON A SCALE OF 1-10, WITH 10 BEING THE MOST SEVERE, CIRCLE THE NO. THAT BEST DESCRIBES THE PROBLEM 1 2 3 4 5 6 7 8 9 10

WHEN DID YOU FIRST NOTICE THE PROBLEM?

2 Days Ago 2 Weeks Ago 1 Month Ago
 Other _____

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

DOES ANYTHING HELP OR MAKE THE PROBLEM WORSE?

Moving Around Standing Up Lying on my Side Other _____

HOW LONG DOES THE PROBLEM LAST?

30 Minutes 1 Hour It is always there Other _____

IS ANYTHING ELSE OCCURRING AT THE SAME TIME?

Nausea Rash Headaches Other _____

IS THE PROBLEM CONSTANT OR VARIABLE?

Dull then Sharp Very Sharp then Leaves Always there Other _____

DOES THE PROBLEM INTERFERE WITH YOUR NORMAL FUNCTIONS?

Yes No If yes, explain _____

CIRCLE ALL CATEGORIES WITH WHICH THE PATIENT NOW OR HAS EVER HAD ANY PROBLEMS (If applicable):

(ALL PATIENTS)

- KIDNEY STONES
- URINARY INFECTION
- BLOOD IN URINE
- FREQUENT URINATION
- INFERTILITY
- HERNIAS
- URINARY LEAKAGE

(MALES)

- IMPOTENCE
- PENILE SORES
- BLOOD IN SEMEN
- EJACULATION/ORGASM
- PENILE DISCHARGE
- TESTICLES
- MISSING A TESTICLE
- PROSTATE PROBLEMS

(FEMALES)

- ABNORMAL BLEEDING OF VAGINA
- TOXEMIA/PREGNANCY
- PAINFUL INTERCOURSE
- VAGINAL DRYNESS
- VAGINAL WARTS
- VAGINAL INFECTION

HAS THE PATIENT EVER BEEN DISABLED OR UNABLE TO WORK? YES or NO

IF YES: WHY? _____ HOW LONG? _____ DISABLED NOW? _____

LIST APPROXIMATE DATE AND REASON FOR ALL SURGERIES AND HOSPITALIZATIONS THE PATIENT HAS HAD:

LIST ALL MEDICINES, VITAMINS, HORMONES, ASPIRIN, ETC. THE PATIENT NOW TAKES

(provide dosages, number times / day if possible):



THE PATIENT'S ALCOHOL CONSUMPTION IS : (circle one)

NONE OCCASIONAL MODERATE CONSIDERABLE

THE PATIENT HAS A DRUG-DEPENDENCY: YES or NO (circle one)

CHECK ANY OF THE FOLLOWING THAT APPLY TO THE PATIENT:

ALLERGIC TO THE FOLLOWING MEDICINES:

NOT ALLERGIC TO ANY MEDICINES

HAVE USED TOBACCO (how long, how much? _____)

IF SO, DOES THE PATIENT STILL SMOKE? YES or NO (circle one)

NUMBER OF CHILDREN _____

FAMILY HISTORY OF:

Diabetes Cancer Prostate Cancer
 Heart Disease Kidney Stones
 Hereditary Disorder Bed-Wetting

PFSH	
# Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

THE PATIENT HAS A HISTORY OF THE FOLLOWING CONDITIONS: (Circle)

Diabetes Cancer Nervousness Radiation
 Depression Back Problems Convulsions Chemotherapy
 Hypertension Stroke Heart Problem Chemical Exposure
 Fainting V.D. Leg Cramps Asthma
 Headaches Weight Loss Bowel Irregularity
 Ulcer Bleed Easily Anesthetic Reaction

NONE OF THOSE LISTED ABOVE

ROS	
# Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

REVIEW OF SYSTEMS (All patients)

The patient currently has this symptom (Check if "YES" or leave blank if "NO") _____ Check here if none below apply

1. CONSTITUTIONAL: Fever _____ Chills _____ Weight loss _____ Weakness _____
2. EYES: Poor vision _____ Blurry vision _____ Double vision _____ Other _____
3. EARS, NOSE, MOUTH: Poor hearing _____ Nosebleed _____ Runny nose _____ Sore throat _____ Other _____
4. CARDIOVASCULAR: Chest pain _____ Palpitations _____ Irregular rhythm _____ Heart murmur _____ Other _____
5. RESPIRATORY: Shortness of breath _____ Cough _____ Sputum production _____ Coughing blood _____ Other _____
6. GI: Blood in stools _____ Constipation _____ Diarrhea _____ Nausea/Vomiting _____ Abdominal Pain _____ Other _____
7. GU: Blood in urine _____ Slow stream _____ Hard to start _____ Incomplete Emptying _____
 Burning with urination _____ Frequency _____ Urgency _____ Incontinence _____
 Night time voiding _____ Flank pain _____ Other _____
8. MUSCULOSKELETAL: Back pain _____ Joint pain _____ Arthritis _____ Muscle aches _____ Other _____
9. INTEGUMENTARY: Skin rash _____ Itching _____ Skin lesions _____ Other _____
10. NEUROLOGICAL: Extremity weakness _____ Numbness _____ Abnormal coordination _____ Gait Problem _____ Other _____
11. PSYCHIATRIC: Disorientation _____ Unusual thoughts _____ Depression _____ Other _____
12. ENDOCRINE: Hot flashes _____ Weight gain _____ Fluid retention _____ Other _____
13. HEMATOLOGY/LYMPHATIC: Enlarged lymph nodes _____ Anemia _____ Bleeding disorder _____ Other _____
14. ALLERGIC/IMMUNOLOGIC: Environmental allergens _____ Allergies to seafood _____ Other _____



REPRODUCTIVE HISTORY (*Female*)

Last Menstrual Period _____ Number of Pregnancies _____

Living Children & Ages: _____

Miscarriages / Still-births _____

My last female examination / Pap Smear was _____ Mammogram _____

Check here if you have not had a normal Pap Smear within last 12 months

Check here if you have not have taken any female hormones within the last year

ONLY MEN WITH IMPOTENCE OR PROBLEMS WITH ERECTIONS NEED TO ANSWER THE FOLLOWING QUESTIONS: Note: All answers will be held in strict confidence!

CHARACTERISTICS OF ERECTIONS: Check all that pertain

- Do you have erections at all?
- Can you accomplish vaginal penetration?
- Do you awaken with erections in the morning?
- Do you lose the erection before ejaculation?
- Do you ejaculate/climax even though the penis is soft?
- Are your erections hard with masturbation?
- Are your erections better when you're on vacation?
- Do you ejaculate before vaginal penetration or too soon after penetration?
- Do you have good erections with a partner different from your Wife?
- Do you or does your partner consider you to have too little sex drive?
- Does it hurt you when you ejaculate/climax?
- Do you have any curvature of the penis during erection?

CHARACTERISTICS OF ORGASM OR CLIMAX:

- Are you ever able to ejaculate with or without a good firm erection?

If so, how often? _____

If so, how is orgasm achieved?

vaginal penetration by hand

rubbing against her oral sex

other

If so, does sperm come out? Yes No

- Can you masturbate to a Climax?
- Do you climax with "wet-dreams?"

CHARACTERISTICS OF SEXUAL OPPORTUNITY:

- Do you have a regular sexual partner?
- Do you and your partner have time available alone together?
- Is your sexual partner cooperative and reasonably responsive?
- Does your partner experience pleasurable sensations and orgasms?