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ASSOCIATES IN UROLOGY NORTH JERSEY, P.A.

Diplomates American Board of Urology

DATE _____ PATIENT DATA FORM

LAST NAME _____ FIRST NAME _____ MI _____

BIRTHDATE _____ AGE _____ M / F SOC.SEC. # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME _____ WORK _____

DO YOU RECEIVE ANTIBIOTICS PRIOR TO DENTAL TREATMENT FOR JOINT REPLACEMENT OR MITRAL VALVE PROLAPSE? YES _____ NO _____

REFERRING MD _____ OCCUPATION _____

MARITAL STATUS : SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED _____ SEPARATED _____

SPOUSE'S NAME _____ NUMBER OF CHILDREN _____

EMERGENCY CONTACT _____ TELEPHONE _____

PHARMACY _____ TELEPHONE _____

PRIMARY CARE MD _____ TELEPHONE _____

INSURANCE POLICY HOLDER _____ DOB _____ SOC.SEC.# _____

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, INCLUDING MAJOR MEDICAL, MEDICARE, BLUE SHIELD, HMO AND COMMERCIAL INSURANCE TO ASSOCIATES IN UROLOGY NO. JERSEY, PA. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL NON-COVERED CHARGES FOR PARTICIPATING INSURANCES AND ALL CHARGES FOR NON-PARTICIPATING INSURANCES. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO SECURE PAYMENT ON MY BEHALF. I AM AWARE THAT I AM RESPONSIBLE TO NOTIFY THIS OFFICE OF ANY CHANGE IN MY INSURANCE CARRIER (S), COVERAGE OR CO-PAY.

DO YOU HAVE A DRUG (P.A.A.D.) CARE? Y N DO YOU HAVE A PRESCRIPTION PLAN? Y N

DATE _____ SIGNATURE _____

I _____ (HIC# _____), REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ASSOCIATES IN UROLOGY NORTH JERSEY, P.A. FOR ANY SERVICES FURNISHED ME BY PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) AND ITS AGENTS ANY BENEFITS PAYABLE FOR RELATED SERVICES.

DATE _____ SIGNATURE _____

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF ASSOCIATES IN UROLOGY NO. JERSEY, P.A.'S NOTICE OF PRIVACY PROTECTION.

DATE _____ SIGNATURE _____

ASSOCIATES IN UROLOGY NORTH JERSEY, PA

NAME _____ SS# _____ DATE _____

REASON FOR VISIT: _____

MEDICAL CONDITIONS (PLEASE LIST): _____

HOSPITALIZATIONS YES ___ NO ___ IF YES WHEN, WHERE AND FOR WHAT CONDITION

SURGICAL PROCEDURES (PLEASE LIST) WHEN PHYSICIAN WHERE TREATED

MEDICATIONS (INCLUDE OVER THE COUNTER) _____

ALLERGIES _____

SMOKE ___ HOW MUCH _____ QUIT WHEN _____ ALCOHOL ___ HOW MUCH _____ QUIT WHEN _____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING:

CANCER _____ DIABETES _____ HEART DISEASE _____ HIGH BLOOD PRESSURE _____ KIDNEY DISEASE _____

INDICATE THE HEALTH STATUS OF FAMILY, IF DECEASED GIVE AGE AND CAUSE OF THE DEATH:

MOTHER _____

FATHER _____

BROTHERS _____

SISTERS _____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following?

PLEASE ANSWER ALL QUESTIONS BY Circling Yes or No

Constitutional Symptoms

Weight change Y N
 Loss of Appetite Y N

Other _____

Eyes

Blurred vision Y N
 Double vision Y N
 Difficulty seeing Y N
 Glaucoma Y N

Other _____

Ear/Nose/Throat/

Ear infection Y N
 Sore throat Y N
 Difficulty hearing Y N
 Wear a hearing aid Y N

Other _____

Cardiovascular

Palpitations Y N
 Chest pain Y N
 Abnormal cholesterol Y N
 High blood pressure Y N
 History of heart attack Y N

Other _____

Respiratory

Wheezing Y N
 Frequent cough Y N
 Shortness of breath Y N
 Emphysema Y N

Other _____

Gastrointestinal

Abdominal pain Y N
 Nausea/vomiting Y N
 Indigestion/heartburn Y N
 Change in bowel habits Y N
 History of colon cancer Y N

Other _____

Gynecologic

Abnormal vaginal bleeding Y N
 Abnormal discharge Y N
 Irregular periods Y N
 Menopause Y N
 History of breast cancer Y N
 Last menstrual period _____

Other _____

Musculoskeletal

Joint pain Y N
 Neck pain Y N
 Back pain Y N
 Arthritis Y N

Other _____

Integumentary

Skin rash Y N
 Boils Y N
 Persistent itch Y N

Other _____

Endocrine

Excessive thirst Y N
 Too hot/cold Y N
 Tired/sluggish Y N
 Thyroid problem Y N

Other _____

Hematologic/Lymphatic

Swollen glands Y N
 Blood clotting problems Y N

Other _____

Neurologic

Stroke TIA Y N
 Tremors Y N
 Dizzy spells Y N
 Numbness or tingling Y N
 Frequent headaches Y N

Other _____

Allergic/Immunologic

Hay fever Y N
 Drug allergies Y N
 Allergic to shellfish Y N
 Take antibiotics prior to dental procedures Y N

Other _____

International Prostate Symptom Score (I-PSS)^{1,2}

Patient's Name _____ Date of Birth _____ Date Completed _____

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 times or more	
7. Nocturia Over the past month, 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?	0	1	2	3	4	5	
Total I-PSS Score							
	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

Adapted with permission from Chatelain C et al, eds.²

The International Prostate Symptom Score (I-PSS) is based on the answers to 7 questions concerning urinary symptoms. Each question allows the patient to choose 1 of 6 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 International Scientific Committee notes that physicians who counsel men with lower urinary tract symptoms (LUTS) use these measures not only during the initial interview but also during and after treatment in order to monitor treatment response.

The International Scientific Committee, under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (IICC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the symptoms assessment tool for patients.¹