

Scioto Valley Urology, Inc.

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Phone: (740) 420-7882

Dear Patient:

- Please assist us by *clearly* and *correctly* completing the information.
- Please give your insurance card(s) to the receptionist for copying.

PATIENT	LAST NAME:	FIRST NAME:	MI:	TITLE:
ADDRESS:		CITY:	STATE:	ZIP:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS: <input type="checkbox"/> SIN <input type="checkbox"/> MAR <input type="checkbox"/> SEP <input type="checkbox"/> DIV <input type="checkbox"/> WID	SOCIAL SECURITY #: ____ - ____ - ____	DATE OF BIRTH: ____ / ____ / ____	
HOME PHONE : () -		WORK PHONE: () -	CELL PHONE: () -	
PREFERRED PHARMACY NAME:		PREFERRED PHARMACY PHONE NUMBER: () -		
REFERRING PHYSICIAN	LAST NAME:	FIRST NAME:	TITLE (ex. M.D. / D.O.)	
ADDRESS:		CITY:	STATE:	ZIP: Phone #: () -
PRIMARY CARE PHYSICIAN	LAST NAME:	FIRST NAME:	TITLE (ex. M.D. / D.O.)	
ADDRESS:		CITY:	STATE:	ZIP: Phone #: () -
EMERGENCY CONTACT (1st)	LAST NAME:	FIRST NAME:	RELATIONSHIP:	
HOME PHONE : () -		WORK PHONE: () -	CELL PHONE: () -	
EMERGENCY CONTACT (2nd)	LAST NAME:	FIRST NAME:	RELATIONSHIP:	
HOME PHONE : () -		WORK PHONE: () -	CELL PHONE: () -	
AUTHORIZATION	<p>THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.</p> <p>I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group, or person(s) necessary to secure payment any information needed for this or related Medicare claim. *For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. * The patient or his / her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations, or other services rendered under the general and specific instructions of the physicians. *I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.</p>			

DATE _____

SIGNATURE X _____

PATIENT (PARENT/GUARDIAN IF MINOR)

Female Medical History

Name: _____ Age: _____ Date of Birth: ____/____/____

Occupation: _____ Retired: Yes No Race: _____

Chief Complaint

(What is the **main reason** for your visit today? Write in your own words on the lines provided below.)

History of Present Illness

Location of the problem: (may choose more than one location).	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Back	<input type="checkbox"/> Groin							
	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Vagina	<input type="checkbox"/> Rectum							
	<input type="checkbox"/> Flank	<input type="checkbox"/> Bladder	<input type="checkbox"/> Thigh							
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
When did you first notice the problem?	<input type="checkbox"/> 2 days ago	<input type="checkbox"/> 2 weeks ago	<input type="checkbox"/> One month ago	<input type="checkbox"/> Other _____						
Does anything help or make the problem worse?	<input type="checkbox"/> Moving around		<input type="checkbox"/> Standing up		<input type="checkbox"/> Lying on side			<input type="checkbox"/> Other _____		
How long does the problem last?	<input type="checkbox"/> 30 minutes		<input type="checkbox"/> 1 hour		<input type="checkbox"/> It is always there			<input type="checkbox"/> Other _____		
Is anything else occurring at the same time? (If yes, please explain).	<input type="checkbox"/> Yes <input type="checkbox"/> No									
Is the problem constant or variable?	<input type="checkbox"/> Dull then sharp		<input type="checkbox"/> Very sharp then leaves		<input type="checkbox"/> Always there			<input type="checkbox"/> Other _____		
Does the problem interfere with your normal functions? (If yes, please explain).	<input type="checkbox"/> Yes <input type="checkbox"/> No									

Past Medical History

(Check if yes only and circle if choice provided)

- | | | |
|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma or Breathing Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Back Pain or Herniated Disk | <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder or Kidney Infections | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urine Incontinence |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bladder Cancer |
| <input type="checkbox"/> Blood Clots or Phlebitis | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Bronchitis or Pneumonia | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Cervical Cancer |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon or Rectal Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Kidney Cancer |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Polio | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> GERD (Gastric Reflux) | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Other Cancer |

Social History

Tobacco	Do you currently smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Did you smoke in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If you stopped smoking, what year?	
	Total number of years you smoked:	
	Number of packs smoked per day:	
	Do or did you chew tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	How much?	
	Do you belong to Alcoholics Anonymous?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recreational Drugs	Drug or Drugs Used:	<input type="checkbox"/> Never <input type="checkbox"/> Rarely
	Quantity:	<input type="checkbox"/> Occasionally <input type="checkbox"/> Daily
		<input type="checkbox"/> Discontinued
Diet and Exercise	Are you on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you add salt to your foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does your health restrict you from exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use: <input type="checkbox"/> walker <input type="checkbox"/> cane <input type="checkbox"/> wheelchair	

Review of Symptoms

(Check if yes only and circle if choice provided)

Anesthesia:

- History of **malignant hyperthermia**?
 Yes No
- Family history of malignant hyperthermia?
 Yes No
- Have you had problems with anesthesia?
 Yes No
- Had nausea or vomiting after anesthesia?
 Yes No

Eyes:

- Do you have trouble with your vision?
 Yes No
- Do you have cataracts?
 Yes No
- Been told that you have **glaucoma**?
 Yes No
- Wear corrective lenses (glasses or contacts)?
 Yes No

Ears, Nose, Throat:

- History of TMJ (jaw) pain?
 Yes No
- Have difficulty hearing?
 Yes No
- Do you wear hearing aides?
 Yes No
- Are you frequently bothered by nosebleeds?
 Yes No
- Have loose teeth/dentures/chips/caps?
 Yes No
- Do you have sinus trouble?
 Yes No
- Has your voice been persistently hoarse?
 Yes No
- Had bleeding gums often this year?
 Yes No
- Had frequent sores on your tongue?
 Yes No

Pulmonary:

- Do you have sleep apnea?
 Yes No
- Do you use a **CPAP** machine?
 Yes No
- Do you use home oxygen?
 Yes No
(Liters/min:)
- Do you have history of asthma?
 Yes No
- Have history of bronchitis or pneumonia?
 Yes No
- Do you have a history of tuberculosis?
 Yes No
- Been told you have emphysema or COPD?
 Yes No

Cardiovascular:

- Have you had episodes of chest pain?
 Yes No
- Ever experience chest pressure or tightness?
 Yes No
- Do you feel your heart racing in your chest?
 Yes No
- Do you take **nitroglycerine** or **nitrates**?
 Yes No
- Have you ever had a heart attack?
 Yes No
- Do your legs or ankles swell?
 Yes No
- Do you have a **pacemaker** or **AICD**?
 Yes No
- Are you short of breath with climbing stairs?
 Yes No
- Do you have a history of murmur?
 Yes No
- Have to take **antibiotics** before dental work?
 Yes No

- Do you have a cardiologist?
 Yes No
 (Name: _____)

Gastrointestinal:

- Do you have nausea or vomiting?
 Yes No
- Have trouble swallowing food or liquids?
 Yes No
- Do you have a history of hiatal hernia?
 Yes No
- Have history of stomach or intestinal ulcers?
 Yes No
- Have a history of acid reflux or GERD?
 Yes No
- Have rectal bleeding or bloody stools?
 Yes No
- Have frequent problems with constipation?
 Yes No
- Have frequent problems with diarrhea?
 Yes No
- Had diverticulosis or diverticulitis?
 Yes No
- Have a history of Crohns disease or colitis?
 Yes No
- Gained/lost more than 20 lbs. in six months?
 Yes No

Genitourinary:

- Do you have burning upon urination?
 Yes No
- Have you ever seen blood in your urine?
 Yes No
- Do you have a history of kidney stones?
 Yes No
- Have you ever had a urinary tract infection?
 Yes No
- Ever had a sexually transmitted disease?
 Yes No
- Leak urine when you cough or laugh?
 Yes No
- Have urgency or frequency of urination?
 Yes No
- Severe urgency that causes urine leakage?
 Yes No
- Do you use protective pads daily?
 Yes No
 (Number: _____)
- Do you urinate more than 8 times daily?
 Yes No

Musculoskeletal:

- Do you often have low back pain?
 Yes No
- Do you have swelling of your joints?
 Yes No
- Do you have any stiffness of your joints?
 Yes No
- Have limitation of motion of your joints?
 Yes No
- Have a history of **joint replacement**?
 Yes No

- Have a history of rheumatoid arthritis?
 Yes No

Integument:

- Do you have hair loss?
 Yes No
- Do you have red, dry patches of skin?
 Yes No
- Do you have skin ulcers?
 Yes No

Neurological:

- Do you often have headaches or migraines?
 Yes No
- Have you ever had a seizure or epilepsy?
 Yes No
- Numbness or tingling in your arms or legs?
 Yes No
- Do you have weakness or paralysis?
 Yes No
- Have you had a stroke?
 Yes No
- Have you had a TIA (mini stroke)?
 Yes No
- Ever fainted or had loss of consciousness?
 Yes No
- Ever had a head or spinal cord injury?
 Yes No

Psychiatric:

- Do you have difficulty sleeping?
 Yes No
- Do you have memory loss?
 Yes No
- Do you have mood swings?
 Yes No
- Have you ever had an anxiety attack?
 Yes No
- Have you ever had hallucinations?
 Yes No

Endocrine:

- Do you have excessive hunger?
 Yes No
- Do you have excessive thirst?
 Yes No
- Have you had problems with infertility?
 Yes No

Hematological/Lymphatic:

- Been told you have a low blood count?
 Yes No
- Do you bruise easily?
 Yes No
- Do you have poor circulation?
 Yes No
- Have you ever had blood clots (phlebitis)?
 Yes No
- Have you ever had a pulmonary embolism?
 Yes No

Allergic/Immunologic:

- Ever had a reaction to a medication?
 Yes No

- Any food allergies (peanuts or shellfish)?
 Yes No
- Have you ever had hives?
 Yes No
- Have seasonal or environmental allergies?
 Yes No

- Have you ever had an asthma attack?
 Yes No
- Are your immunization shots up to date?
 Yes No
- Do you have a **latex** or **rubber** allergy?
 Yes No

Have You Ever Been on Any of the Following Medications?

Alpha Blockers:

- Flomax (tamsulosin)?
 Yes No
- Uroxatral (alfuzosin)?
 Yes No

Anticholinergic Medications:

- Ditropan XL (oxybutynin)?
 Yes No
- Detrol LA (tolterodine)?
 Yes No
- Oxytrol Patch (oxybutynin)?
 Yes No
- Vesicare (solifenacin)?
 Yes No
- Sanctura (trospium)?
 Yes No
- Enablex (darifenacin)
 Yes No

Sex Steroid Hormones:

- Estrogen/Premarin/Estrace/Vagifem?
 Yes No
- Estrogen by mouth or patch?
 Yes No

Antibiotics:

- Macrobid (nitrofurantoin)?
 Yes No
- Cipro (ciprofloxacin)?
 Yes No
- Levaquin (floxacin)?
 Yes No
- Proloprim (trimethoprim)?
 Yes No
- Bactrim/Septtra?
 Yes No

OVERACTIVE BLADDER VALIDATION QUESTIONNAIRE

<i>How Bothered have you been by...</i>	Not at All	A Little Bit	Some-what	Quite a Bit	A Great Deal	A Very Great Deal	
Frequent urination during the daytime hours? 788.41	0	1	2	3	4	5	
An uncomfortable urge to urinate? 788.63	0	1	2	3	4	5	
A sudden urge to urinate? 788.63	0	1	2	3	4	5	
Accidental loss of small amounts of urine? 625.6	0	1	2	3	4	5	
Nighttime urination? 788.43	0	1	2	3	4	5	
Waking up at night because you had to urinate? 788.43	0	1	2	3	4	5	
An uncontrollable urge to urinate? 788.31	0	1	2	3	4	5	
Urine loss associated with a strong desire to urinate? 788.31	0	1	2	3	4	5	
	Delighted	Pleased	Satisfied	Mixed	Dissatisfied	Unhappy	Terrible
Bothersome of Urinary Symptoms: How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6