Advanced Urology Specialists, LLC
Patient Information Sheet

Date: _____ SS # _____

Date of Birth_____ Sex: (Circle) M F

Pt. Name _____
Last Name First Name MI

Perm. Address: _____ City_____ St _____ Zip_____

Summer/Winter Address: _____ City_____ St_____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

*Email _____ Employer Name_____

Primary Physician: _____ Referring Physician: _____

Pharmacy:_____ *Location:* _____ *Phone No.* _____

Emergency Contact _____ *Address* _____ *Phone #*_____

Spouse's Name _____ DOB _____ SS #_____

Address: If different than above _____ City_____ St _____ Zip_____

Home # _____ Cell # _____ Work # _____

Financially Responsible Party: _____ Relationship_____

Primary Ins. Co. _____ Phone _____
Policy Subscriber Name _____ DOB _____
Relationship to Pt._____ SS # _____ Policy # _____ Group # _____

Secondary Ins. Co. _____ Phone _____
Policy Subscriber Name _____ DOB _____
Relationship to Pt._____ SS # _____ Policy # _____ Group # _____

Third Ins. Co. _____ Phone _____
Policy Subscriber Name _____ DOB _____
Relationship to Pt._____ SS # _____ Policy # _____ Group # _____
_____ Phone _____

Authorization to Release Medical Information
I hereby authorize the above physician to release any information Necessary to process my insurance claim.

Authorization to Pay Benefits.
I hereby authorize lifetime payment of medical benefits to The above named physician/group medical.

Payment for services is expected at the time of service, unless advance payment arrangements have been made. Insurance is filed as a courtesy, It does not eliminate the patient's responsibility for payment. I certify the information I have provided is correct.

Patient Signature _____ Date _____

See Other Side

Advanced Urology Specialists, LLC

Date: _____ **COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION**

Name: _____ **Date of Birth:** _____

Advanced Urology Specialists is authorized to release protected information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information: Check each person/entity that you approve to receive any personal or medical information	**Description of Information to be Released:** Please circle each area of information that may be given to the person/entity listed on the left in the same section.
○ Answering Machine	○ Messages regarding appointments, lab tests/ x-rays or procedures ○ Any other information regarding treatment ○ Any information regarding Medications
○ Spouse (provide Name and Date of Birth) _____	○ Billing Information ○ Financial / Insurance Information ○ Medical Information (treatments, results, etc)
○ Parents/Children (Provide name & DOB) _____ _____ _____ _____	○ Billing Information ○ Financial / Insurance Information ○ Medical Information (treatments, results, etc)
○ Other (provide name, DOB or password) _____	○ Billing Information ○ Financial / Insurance Information ○ Medical Information (treatments, results, etc)

EXPIRATION DATE: Provide an expiration date that this authorization will expire. _____

If no expiration date is given, this authorization will expire 1 year from the below signature date!

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Advanced Urology Specialists, LLC. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: _____

_____

Advanced Urology Specialists, LLC

Date: _____ **PATIENT QUESTIONAIRE**

Name: _____ Age _____ Date of Birth_____

Other Physicians involved in your care: _____

Date of Last Flu shot_____ **Date of Pneumonia Shot** _____

Medicines You are ALLERGIC to:	**Surgeries you have had:** **Year**	**Medications you take: Include Over-the-counter and supplements, vitamins**

FAMILY HISTORY: Has your Mother, Father, Brothers, Sisters or Children had any problems listed below: (please circle)

Hematuria	Y	N	**Heart Disease**	Y	N	**Easy Bleeding**	Y	N
Bladder Cancer	Y	N	**Kidney Disease**	Y	N	**Prostate Cancer**	Y	N
Kidney Stones	Y	N	**Hypertension**	Y	N	**Diabetes**	Y	N

SOCIAL HISTORY: **Marital Status**: (Circle) Married Single Divorced Widowed Separated

Do you Smoke? (Circle) Current Every Day Current Some Day Former Smoker Never Smoker Quit When? _____

Alcohol Use: (Circle) Yes Not Anymore Never **How Many Per Day** _____ **Caffeinated drinks per day**: _____

Race: (Circle) White Black Amer Indian/Alaska Asian Hawaiian Hispanic or Latino Unknown

Ethnicity (Circle) Hispanic/Latino Not Hispanic/Latino **Pref Language**: _____

IT IS IMPORTANT THAT THE DOCTOR IS AWARE OF ANY PROBLEMS YOU MAY HAVE OTHER THAN YOUR URINARY TRACT. PLEASE CIRCLE YES OR NO TO ANY OTHER PROBLEMS YOU MAY HAVE AT THIS TIME.

CONSTITUTIONAL			**Respiratory**			**Integumentary / Skin**		
Fever	Y	N	Shortness of Breath	Y	N	Rash	Y	N
Chills	Y	N	Wheezing	Y	N	Persistent Itching	Y	N
Weight Loss	Y	N	Chronic Cough	Y	N	Skin Cancer History	Y	N
EYES			**Gastrointestinal**			**Neurological**		
Blurry Vision	Y	N	Abdominal Pain	Y	N	Numbness	Y	N
Double Vision	Y	N	Nausea/Vomiting	Y	N	Tingling	Y	N
Cataracts	Y	N	Change in Bowels	Y	N	Dizziness	Y	N
EAR / NOSE / THROAT / MOUTH			**Genitourinary**			**Hematologic / Lymphatic**		
Hearing Loss	Y	N	Incontinence	Y	N	Swollen Glands	Y	N
Nasal Stuffiness	Y	N	Blood in Urine	Y	N	Abnormal Bleeding	Y	N
Sore Throat	Y	N	Sexual Dysfunction	Y	N	Easy Bruising	Y	N
Cardiovascular			**Musculoskeletal**			**Endocrine**		
Chest Pains	Y	N	Chronic Back Pain	Y	N	Low Libido	Y	N
Irregular Heartbeat	Y	N	Chronic Neck Pain	Y	N	Low Energy Level	Y	N
High Blood Pressure	Y	N	Arthritis	Y	N	Excess Thirst	Y	N

Advanced Urology Specialists, LLC

To help the Doctor more efficiently serve you, please answer the following questions:
These questions are designed to assess your urinary symptoms over the last month or so. Please check your closest answer.

1. How often do you sense that you have not emptied your bladder completely after you finish urinating?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
2. How often have you had to urinate again less than 2 hours after you finished urinating?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
3. How often have you found it difficult to postpone urination?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
4. How often have you had a weak urinary stream?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
5. How often have you found you stopped and started again several times when you urinated?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
6. How often have you had to push or strain to begin urination?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
7. 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 or more times

Have you ever seen blood in your urine? ☐ Yes ☐ No

Does it burn or hurt when you urinate? ☐ Yes ☐ No

Have you had infections in the bladder? ☐ Yes ☐ No

Have you had infections in the kidneys? ☐ Yes ☐ No

Have you had infections in the prostate? ☐ Yes ☐ No

Have you ever had kidney stones? ☐ Yes ☐ No

Do you leak urine? ☐ Yes ☐ No

What causes you to leak? _____

Do you ever leak when you cough, sneeze or laugh? ☐ Yes ☐ No

What about when you exercise? ☐ Yes ☐ No

If you are a man, please answer these also:

When was the last time a doctor checked the prostate with a rectal finger exam? _____

When was your last PSA (Prostate Specific Antigen, the prostate cancer blood test)? _____

Can you recall the result? _____

Have you been told the prostate exam was abnormal? ☐ Yes ☐ No

Have you had a prostate biopsy? ☐ Yes ☐ No When? _____

Have you been told you prostate was enlarged? ☐ Yes ☐ No

Have you had the prostate "worked on"
(surgery, "roter rooter", TURP, dilations)? ☐ Yes ☐ No When? _____

Name: _____