

Urology Partners

44344 Dequindre, #210 – Sterling Heights, MI 48314

1455 South Lapeer Rd., #122 – Lake Orion, MI 48360

15959 Hall Rd., #401 – Macomb, MI 48044

586.323.4200 – Sterling Heights 248.814.6000 – Lake Orion 586.412.5700 – Macomb

NAME _____

DATE _____

DATE OF BIRTH _____

REFERRED BY: _____

CHIEF COMPLAINT - Reason for visit:

Medical History Information:

Do you currently have or have you had in the past any of the following? Please Explain

	Y	N	If yes, what kind of cancer
Cancer			
Heart disease			
Coronary artery disease			
Congestive heart failure			
Irregular heartbeat			
Heart murmur			
Mitral valve prolapse			
Do you take antibiotics prior to dental procedures?			
Pacemaker			
Peripheral vascular disease			
Diabetes			
Hypertension (high blood pressure)			
Elevated cholesterol level			
Kidney stone			
Lump in breast			
Lump in scrotum			
Stroke			
Tuberculosis			
Chronic obstructive pulmonary disease (COPD)			
Asthma			
Hepatitis			
Liver disease			
Peptic ulcer disease			
Thyroid problems			
Seizures			
Arthritis			
Anemia			
Cataracts			
Glaucoma			

Height	Weight	
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MALE PATIENTS ONLY	FEMALE PATIENTS ONLY
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Date of last prostate exam	Date of last menstrual period
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Most recent PSA result	No. of pregnancies	Live births
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PLEASE LIST ALL ADDITIONAL MEDICAL PROBLEMS

PLEASE LIST ALL SURGICAL PROCEDURES**YEAR PERFORMED**

Social History Information
 MARRIED SINGLE DIVORCED WIDOWED

Number of children						
Do you currently smoke cigarettes?	Y	N	How many?	For how long?		
Do you smoke cigars/pipe	Y	N				
Do you chew tobacco?	Y	N				
Did you smoke in the past? If yes, when did you quit?	Y	N	How many?	For how long?		
Do you drink caffeinated beverages? Coffee – Tea – Soda	Y	N	How many per day?			
Do you drink alcohol?	Y	N	Rarely	Occasionally	Moderately	Heavily

Family History Information**Is there a family history of any of the following?**

Cancer	Y	N	If yes, what kind of cancer			
Diabetes	Y	N	Bleeding disorders	Y	N	
High blood pressure	Y	N	Other (please explain)	Y	N	
Heart disease	Y	N				

Please list the name, address and phone number of all physicians you see.

DO YOU HAVE A LIVING WILL? YES NO

If yes, please be advised that this office does not honor living wills. If the need arises, we will transfer you to a facility that does honor living wills.

I hereby authorize my insurance company to forward payment of medical benefits to Urology Partners. I also authorize Urology Partners to release to said insurance company all necessary information required to process my claim.

I have been provided with information about the physicians at Urology Partners.

Patient Signature (parent or guardian if patient is a minor)

Date

PATIENT NAME

REVIEW OF SYSTEMS

DATE OF VISIT

In the last six months have you had any problems related to the following systems?
 Circle **Y**es or **N**o. Please explain any yes answers.

Constitutional		Treating Physician	Cardiovascular		Treating Physician
Fever	Y N		Chest pain	Y N	
Chills	Y N		Varicose veins	Y N	
Weight loss	Y N		High blood pressure	Y N	
Headache	Y N		Low blood pressure	Y N	
Other			Other		
Explanation			Explanation		
Eyes		Treating Physician	Integumentary		Treating Physician
Blurred vision	Y N		Skin Rash	Y N	
Double vision	Y N		Boils	Y N	
Pain	Y N		Persistent itch	Y N	
Other			Other		
Explanation			Explanation		
Allergic/Immunologic		Treating Physician	Musculoskeletal		Treating Physician
Hay fever	Y N		Joint pain	Y N	
Drug allergies	Y N		Neck pain	Y N	
Other			Other		
Explanation			Explanation		
Neurological		Treating Physician	Ears/Nose/Throat		Treating Physician
Tremors	Y N		Ear infection	Y N	
Dizzy spells	Y N		Hearing loss	Y N	
Numbness	Y N		Sore throat	Y N	
Tingling	Y N		Sinus problems	Y N	
Other			Other		
Explanation			Explanation		
Endocrine		Treating Physician	Genitourinary		Treating Physician
Excessive thirst	Y N		Urine retention	Y N	
Feels extremely hot	Y N		Painful urination	Y N	
Feels extremely cold	Y N		Urinary frequency	Y N	
Unusually tired/sluggish	Y N		Blood in urine	Y N	
Other			Urine incontinence	Y N	
Explanation			Other		
Gastrointestinal		Treating Physician	Respiratory		Treating Physician
Abdominal pain	Y N		Wheezing	Y N	
Nausea	Y N		Frequent cough	Y N	
Vomiting	Y N		Shortness of breath	Y N	
Diarrhea	Y N		Other		
Constipation	Y N		Explanation		
Indigestion/heartburn	Y N		Hematologic/Lymphatic		Treating Physician
Other			Swollen glands	Y N	
Explanation			Blood clotting issues	Y N	
Patient Signature		Date	Other		
			Explanation		

Physician Signature

Date

MA Initials

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UROLOGY PARTNERS
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Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmission of your prescriptions to mail order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy, however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) as any information provided will be helpful.

PATIENT NAME			
Address			
City, State, Zip			
Phone #			
MAIN PHARMACY			
Name (i.e. CVS, Rite-Aid, etc.)			
Street Name, City			
Phone #		Fax #	
ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE			
Name (i.e. CVS, Rite-Aid, etc.)			
Street Name, City			
Phone #		Fax #	
Name (i.e. CVS, Rite-Aid, etc.)			
Street Name, City			
Phone #		Fax #	
MAIL ORDER			
<input type="checkbox"/>	Medco	<input type="checkbox"/>	Express Scripts, Inc.
<input type="checkbox"/>	CareMark	<input type="checkbox"/>	PharmaCare
Please list your drug allergies:			

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Date _____

International Prostate Symptom Score	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	Your score
1) <u>INCOMPLETE EMPTYING</u> 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) <u>FREQUENCY</u> Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3) <u>INTERMITTENCY</u> 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) <u>URGENCY</u> Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5) <u>WEAK STREAM</u> Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6) <u>STRAINING</u> 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 / more times	
7) <u>NOCTURIA</u> 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 =							
Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed equally satisfied / dissatisfied	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

Patient Signature

TOTAL SCORE

SEX	M	F		DATE	
NAME				AGE	DATE OF BIRTH
ADDRESS					
CITY, STATE, ZIP					
SOCIAL SECURITY NO.				HOME PHONE	
EMPLOYER				BUSINESS PHONE	
EMERGENCY CONTACT			RELATION	PHONE (OTHER THAN HOME PHONE)	
REASON FOR SEEING DOCTOR					
REFERRED BY				ALLERGIC TO	
<u>INSURANCE INFORMATION</u>					
CARDHOLDER NAME				CARDHOLDER SOCIAL SECURITY NO.	
CARDHOLDER DATE OF BIRTH			RELATIONSHIP TO CARDHOLDER		