

**WELCOME TO THE UROLOGY GROUP OF PRINCETON Page 1 of 4**

**Where did you first hear about our practice? (Please Check one)**

A friend     Yellow Pages     Newspaper Ad     Family     Physician Referral     Other

Last Name		Type of Insurance (circle) Medicare    HMO/PPO/POS    Other	
First Name, Middle initial		Person Responsible for bill: Self    Parent    Other	
Street Address		Date of Birth	
City, State		Referring Doctor	Family Doctor
Zip Code		Patient Occupation	
Social Security # (Parent or Guardian)		Name & Address of Employer	
Home Telephone Number		Pharmacy, Location & Phone #	
Work Telephone Number		Medication Allergies (List all)	
Gender (Circle One)    Male    Female		Drivers License #	
Marital Status (Circle one) Single    Married    Divorced    Widowed		Spouse's Name _____ Number of Children _____	
Primary Insurance Co.	Secondary Insurance Co.	Tertiary Insurance Co.	
Name of Primary Insured	Primary Insured Date of Birth		
Is Medicare your Secondary Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes - if yes check the applicable reason below <input type="checkbox"/> Working Aged Beneficiary or Spouse w/Employer Plan <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> No Fault Insurance Including Auto as Primary <input type="checkbox"/> Veteran's Administration <input type="checkbox"/> Public Health Service(PHS) or other Federal Group <input type="checkbox"/> Other Liability Insurance Primary <input type="checkbox"/> Disabled Beneficiary under Age 65 with Large Group Health Plan (LGHP)			

Do you have a living will? Yes    No    Do you want information regarding a living will? Yes    No  
 I hereby extend authorization to be seen, examined and treated by the Urology Group of Princeton physicians and staff as indicated by the standard of Urologic practice.

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I hereby request that payment of authorized (Medicare/Private Insurance) benefits be made either to me or on my behalf to the Urology Group of Princeton for any services furnished to me by that physician or supplier. I also authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for a related service.

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I hereby authorize the release of medical information to my referring physician and I understand that any charges incurred by the above named patient are my responsibility.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Medical Information**

**Explain briefly what brought you to the office to see the doctor today:**


What is your approx Height? \_\_\_\_\_ Ft. \_\_\_\_\_ Inches      Approx Weight? \_\_\_\_\_ Lbs.

**Genito-Urinary History**

	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
<b>Incomplete Emptying</b> – Over the past few months how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
<b>Intermittency</b> – Over the past month how often have you found you stopped and started again several times during urinating?	0	1	2	3	4	5
<b>Urgency</b> – Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>Frequency</b> – 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
<b>Weak Stream</b> – Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
<b>Straining</b> – Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
<b>Nocturia</b> – How many times do you typically get up at night to urinate, from the time you go to bed until the time you get up in the morning?	0 times	1 time	2 times	3 times	4 times	5 times

**Total Score** \_\_\_\_\_

**If you were to spend the rest of your life with your voiding condition just the way it is now, how would you feel about that? (Circle your answer)**

**Delighted    Pleased    Mostly Satisfied    Mixed    Most Dissatisfied    Unhappy    Terrible**

**Do you have leakage of urine?**       Yes     No

**How many pads do you use each day (if applicable)?**      \_\_\_\_\_ Pads per day

**Do you have:**  
**A history of bladder, kidney or prostate infections?**       Yes     No

**A history of blood in the urine?**       Yes     No

**A history of kidney stones?**       Yes     No

**Difficulty or dissatisfaction with sexual function?**       Yes     No

**A history of HIV/Venereal Disease?**       Yes     No

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Page 3 of 4

*Please review the following review of systems and check off any symptoms that have effected your current and prior health. If you have not experienced symptoms in a particular system check "negative".*

<p><b>Constitutional:</b></p> <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever/Chills, Sweats <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>	<p><b>Psychiatric:</b></p> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>
<p><b>Eyes:</b></p> <input type="checkbox"/> Blurry Vision/glasses <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>	<p><b>Gastrointestinal:</b></p> <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>
<p><b>Ears/Nose/Mouth/Throat:</b></p> <input type="checkbox"/> Ringing in Ears/Hearing Loss <input type="checkbox"/> Nasal Discharge/Bleeding <input type="checkbox"/> Sore Throat <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>	<p>Gynecologic: (Woman only)</p> <input type="checkbox"/> Menopause/ Abnormal Menses <input type="checkbox"/> Breast Lump <input type="checkbox"/> Vaginal Discharge/Problems <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>
<p><b>Cardiovascular:</b></p> <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Chest Pain (Angina)/Heart Attack <input type="checkbox"/> Heart Murmur/Valve Problem <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> Hypertension/High Blood Pressure <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>	<p><b>Respiratory:</b></p> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>
<p><b>Musculoskeletal:</b></p> <input type="checkbox"/> Joint Pain/Arthritis <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>	<p><b>Endocrine:</b></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Adrenal Disease <input type="checkbox"/> Erectile Dysfunction/Loss of Libido <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>
<p><b>Skin:</b></p> <input type="checkbox"/> New Skin Lesion <input type="checkbox"/> Rash/Dry Skin <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>	<p><b>Hematological:</b></p> <input type="checkbox"/> Easy Bruising/Bleeding <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>
<p><b>Neurologic:</b></p> <input type="checkbox"/> Numbness of Arms/Legs/Face <input type="checkbox"/> Weakness of Arms/Legs/Face <input type="checkbox"/> Memory Loss <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Negative</b>	<p>Reviewed By: _____          (Physician's signature)</p> <p>Date reviewed: _____</p> <p>Re-review _____</p> <p>_____</p>

Please list any gynecological problems for which you have been treated.


**Medication History**

Do you have a heart murmur, heart valve or joint replacement that requires antibiotics for dental work?

Yes No

Are you currently taking any medications or vitamins? Yes (please specify) No

**Specify current medication Dosage How often taken**

Specify current medication	Dosage	How often taken
Aspirin, Antinflammatories, Coumadin, Vitamin E, Herbs		

**History of Medical Illness**

List all condition for which you have received evaluation or treatment such as asthma, heart disease, high blood pressure, elevated cholesterol, ulcers, diabetes, strokes, etc.

**Date Specify type of Medical Illness**


**History of Surgery**

List all surgeries which you have had including appendectomy, hysterectomy, tonsillectomy, hernia repair, etc.

**Date Specify type of Surgery**


**Social/Family History**

Do you currently smoke? No Yes \_\_\_packs per day for the last \_\_\_ years

Have you been a smoker in the past? No Yes \_\_\_ years Quit? \_\_\_# years ago

Do you drink wine, beer or alcoholic beverages? daily socially rarely never

How many cups of caffeinated beverages (coffee, tea, cola) do you consume in a day? \_\_\_#of cups

Do you have a family history of Cancer? Yes No

Do you exercise regularly? Yes No

Circle if any family history of Genito Urinary Cancer – Prostate, Kidney, Bladder, Uterine, Ovarian, Breast

Reviewed By Physician: \_\_\_\_\_

Physician's Subsequent review: \_\_\_\_\_