

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 () - Leave detailed message Yes ____ No _____		Pharmacy, Location & Phone #	
Cell Telephone () - Leave detailed message Yes ____ No _____		Emergency Contact	
Work Telephone () -		() -	
E-Mail		Drivers License #	
Gender (Circle One) Male Female Marital Status (Circle one) S M D W		Spouse's Name _Number of Children	
Primary Insurance Co.	Secondary Insurance Co.	Tertiary Insurance Co.	
Name of Primary Insured	Primary Insured Date of Birth	E-mail Address	
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 for myself or the above named patient to be seen, examined and treated by the Urology Group of Princeton physicians and staff as indicated by the standard of Urologic practice.
- I hereby request that payment of authorized (Medicare/Private Insurance) benefits be made 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 for a related service.
- I hereby authorize the release of medical information to my referring physician
- I understand that any charges incurred by myself or the above named patient are my responsibility.
- I understand that a no show charge of \$25 or \$50 might be incurred if I do not cancel my appointment 1 business day before my appointment
- **Patient/Guardian Signature** _____ **Date** _____

Patient Medical Information

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

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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
Incomplete Emptying – 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
Intermittency – Over the past month how often have you found you stopped and started again several times during urinating?	0	1	2	3	4	5
Urgency – Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Frequency – 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
Weak Stream – Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Nocturia – 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

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>Constitutional:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever/Chills, Sweats <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative 	<p>Psychiatric:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative
<p>Eyes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blurry Vision/glasses <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative 	<p>Gastrointestinal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative
<p>Ears/Nose/Mouth/Throat:</p> <ul style="list-style-type: none"> <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"/> Negative 	<p>Gynecologic: (Woman only)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Menopause/ Abnormal Menses <input type="checkbox"/> Breast Lump <input type="checkbox"/> Vaginal Discharge/Problems <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative
<p>Cardiovascular:</p> <ul style="list-style-type: none"> <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"/> Negative 	<p>Respiratory:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative
<p>Musculoskeletal:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint Pain/Arthritis <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative 	<p>Endocrine:</p> <ul style="list-style-type: none"> <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"/> Negative
<p>Skin:</p> <ul style="list-style-type: none"> <input type="checkbox"/> New Skin Lesion <input type="checkbox"/> Rash/Dry Skin <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative 	<p>Hematological:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Easy Bruising/Bleeding <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Other _____ <input type="checkbox"/> Negative
<p>Neurologic:</p> <ul style="list-style-type: none"> <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"/> Negative 	<p>Reviewed By: _____ (Physician's signature)</p> <p>Date reviewed: _____</p> <p>Re-review _____</p> <p>_____</p>

How many pregnancies? _____ How Many children? _____

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
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Aspirin, Antinflammatories, Coumadin, Vitamin E, Herbs		

DO YOU HAVE ANY ALLERGIES YES NO

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
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History of Surgery

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

Date	Specify type of Surgery
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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: _____