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? ☐ No ☐ Yes - if yes check the applicable reason below

□ Working Aged Beneficiary or Spouse w/Employer Plan □ Workers' Compensation
□ No Fault Insurance Including Auto as Primary □ Veteran's Administration
□ Public Health Service(PHS) or other Federal Group □ Other Liability Insurance Primary
□ 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:

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	Abut 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".

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

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
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

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: _____