Urology Group of Princeton

Last Name	**Type of Insurance (circle):** **Medicare HMO/PPO/POS Other**	
First Name, Middle initial	**Person Responsible for bill (circle):** **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 Name** **Phone # ( )**	
Work Telephone ( )		
E-Mail	**Drivers License #**	
Gender (circle): Male Female **Marital Status (circle): 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**

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 authorize the release of medical information to my referring physician

_____ _____
Signature of Patient or Responsible Party Print Name of Patient

_____ _____
Relationship/Authority of Responsible 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
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	I	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):

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) _____

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/Veneral Disease? Yes No

Please review the following and check off any symptoms that have affected 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	

Social/FamilyHistory

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? ____ 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

Medication History

Do you have any allergies? No If Yes, please list _____

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 below) No

Medication	Dosage	Frequency
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	Type of Medical Illness

History of Surgery

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

Date	Type of Surgery

GYNHistory (Women Only)

How many pregnancies? _____ __ How Many children? _____
Please list any gynecological problems for which you have been treated: