Las Vegas Pediatric Urology

Adult Demographics Form

Patient's Name:	Preferred Name:	Age:
Patient's Social Security Number:	Date of Birth:	Sex: M / F

Home Address: ______________________________ Apt: ________

City: ______________________ State: _________ Zip:______________

Cell phone #: _______________ Home Phone #: ________________ Work phone #: ______________

Email: ______________________________ Marital Status: ____________________________

Spouse's Name: Social Security Number: Address: City: State: Zip: Cell phone #: Home phone #: Email address:	**Race:** Please choose one (circle your choice) Asian Native Hawaiian Other Pacific Islander Black / African American American Indian / Alaskan Native White More than 1 Race Unreported / Refused to report **Ethnicity**: Please choose one (circle your choice) Hispanic / Latino NOT Hispanic / Latino Unreported / Refused to report **Preferred Language:** ________________________

Emergency Contact: Phone #:

Relationship:

Insurance Information

Primary Insurance:	Phone #:	
Claim Address: City: State: Zip:		
Subscriber Name:	Policy #:	Group #:
Subscriber relationship to patient:	Subscriber DOB:	
Employer Name: Phone #: Occupation:		
Secondary Insurance:	Phone #:	
Claim Address: City: State: Zip:		
Subscriber Name:	Policy #:	
Subscriber relationship to patient:	Subscriber DOB:	
Employer Name: Phone #: Occupation:		

Adult Patient Medical Information

Name:______________________________

Primary Care Physician's Name:		
Phone #:	Fax #:	Practice Name:

REASON FOR VISIT: ____

UROLOGIC CONDITIONS:
- [ ] Kidney stones
- [ ] Frequent Urination
- [ ] Slow urine stream
- [ ] Urinary tract infection
- [ ] Blood in urine
- [ ] Difficulty with erection
- [ ] Scrotal swelling
- [ ] Urine Incontinence
- [ ] Abnormal PSA

[ ] Other: _______________________________________

ALLERGIES to Medications: [ ] None

1____________________ Medication causing allergy _________________________ Reaction

2.____________________ Medication causing allergy __________________ Reaction

3.___________________ Medication causing allergy ______________ Reaction

CURRENT MEDICATIONS: [ ] None 1.___________________ 2.________________________

3.________________ 4.______________________ 5. __________________ 6.__________________

PHARMACY Name: ___________________________	Phone:_______________________________
Street address: ____	City: _____________________

MEDICAL HISTORY: Check all conditions for which apply:

___Diabetes mellitus ___Hypertension ___Emphysema/COPD ___Asthma

___Heart troubles ___Thyroid disease ___Ulcer disease ___Gout

___Stroke ___Diverticulosis ___Colitis ___Glaucoma

___Liver disease/cirrhosis/hepatitis ___Cancer. Site of origin: ____________________

___Anemia/bleeding disorders Other: ___________________________________

PRIOR SURGERIES: [ ] None Please list the procedure and the year it was performed.

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

FAMILY HISTORY: Please list medical conditions present in your family.

Mother	Father	Siblings
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

SOCIAL HISTORY: Check all that apply:

Marital status: ____Married ____Single ___Divorced ___ Widowed ___Separated

Smoking: ____Never Smoked ____Former Smoker ____Current Smoker, ____ packs per day

Alcohol: ____Never ______Quit ______Yes, ______drinks per day

Caffeinated drinks: ______per day

Blood transfusion in the past: ______ Yes ______ No

Recreational drug use: ___Never ___Former user ____Current user, drug of choice________

REVIEW OF SYSTEMS: If you have any of the symptoms below, please circle the condition

GENERAL	HEAD & NECK	CARDIOVASCULAR
Fever Night sweats Unexpected weight loss Difficulty sleeping Loss of Energy	Blurry or double vision Temporary blindness Ringing in ears Ear infections Difficulty smelling Nose bleeds easily Difficulty swallowing Sore throat Lump in neck	Short of breath on exertion Chest pain Irregular heartbeat Leg pain with exertion Swelling in ankles Wake up at night short of breath
RESPIRATORY	**GASTROINTESTINAL**	**HEMATOLOGIC**
Chronic cough Cough up blood Shortness of breath at rest Wheezing History of pneumonia or bronchitis	Indigestion or heartburn Stomach ulcers Vomiting blood Blood in stool Tarry stool Chronic diarrhea / colitis Jaundice Chronic constipation	Easy bruising or bleeding tendencies Anemia Poor immune system On blood thinners
MUSCULOSKELETAL	**SKIN & BREAST**	**ENDOCRINE**
Pain or swelling in joints Pain in the spine	Lumps or pain in breast Nipple discharge Abnormal breast engorgement	Temperature intolerance Thyroid problems Excessive thirst Steroid use
GYNECOLOGIC	**NEUROLOGIC/PSYCHIATRIC**	**GENITOURINARY**
Abnormal PAP smear Pain with intercourse Vaginal dryness Frequent vaginal infections Hot flashes Prior PID or tubal infections	Weakness in extremities Numbness or tingling in extremities Pain shooting down extremities Seizures Dizziness Vertigo (room spinning around you) Chronic depression Anxiety disorder	Blood in urine Kidney or bladder stones Kidney or bladder infections Loss of bladder or bowel control Pain or burning with urination Leak urine with cough, sneeze, or laugh Leak urine with urge

LAS VEGAS UROLOGY

Las Vegas Pediatric Urology

International Voiding Symptom Score

Patient Name ______________________ **Date of Birth** ____________ **Date** ____________

Please answer the questions below with a ranking of your symptoms.	Not at all. 0	Less than 1 time in 5. 1	Less than half the time. 2	About half the time. 3	More than half the time. 4	Almost always. 5	Your Score:
1. Incomplete Emptying 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. 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	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when urinating?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. Nocturia (Night Time) Over the past month, how many times did you usually 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	

Quality of life due to urinary symptoms. 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?	Delighted	Pleased	Mostly Satisfied	Mixed Feelings	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6

Last Updated 10/05/11

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By signing below, I certify that I have reviewed and agree to the following:

- AUTHORIZATION AND AGREEMENT TO OFFICE POLICIES AND FEES
- NOTICE OF PRIVACY PRACTICES
- AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
- PHYSICIAN-PATIENT ARBITRATION AGREEMENT

I understand that I may request to keep a copy of the above forms.
The forms are also available for review and download online at www.lasvegaspediatricurology.com.

A photocopy of this authorization is as valid as the original.

______________________________________ ____________________
Patient or Patient Representative Signature Date

______________________________________ ____________________
Print Name of Patient of Patient Representative Social Security Number

____
Relationship to Patient (Self, Parent, or Legal Guardian)