KASRAEIAN UROLOGY

New Patient-Female

Date: _____

Patient Information:

Last Name: _____ **First Name:** _____ **MI:** _____ **DOB:** _____

M/F SS#: _____ **Marital Status:** _____ **Email:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Leave a message: Home** ☐ **Cell** ☐

Your Employer: _____ **Occupation:** _____

Emergency Contact: _____ **Phone #:** _____ **Relationship:** _____

Insurance Information: This information is required by your insurance company for verification.

Primary Insurance: _____ **Member Id:** _____ **Are you the policy holder: Yes** ☐ **No** ☐

If No, Policy Holder's Name: _____ **DOB:** _____ **Relationship:** _____

Policy Holder's address: _____ **Phone #:** _____ **M/F**

Secondary Insurance: _____ **Member Id:** _____ **Are you the policy holder: Yes** ☐ **No** ☐

If No, Policy Holder's Name: _____ **DOB:** _____ **Relationship:** _____

Policy Holder's address: _____ **Phone #:** _____ **M/F**

Patient Referral Information:

Referring Physician: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

Please list any other Specialist:

Physician: _____ **Specialty:** _____ **Phone #:** _____

Physician: _____ **Specialty:** _____ **Phone #:** _____

Physician: _____ **Specialty:** _____ **Phone #:** _____

Please have all insurance cards, Driver's license or State Id, and Copayment (if applies) Available upon check-in.

Pharmacy:

Local Pharmacy Name:_____

Approx. location/address: _____

Phone number:_____

Mail Order Pharmacy:_____

Medications- Please list all current medications & supplements or attach separate list. (please print)

Start Date	Medication/Supplement	Dose	How Often	RX	OTC	Prescribing Doctor

Allergies- Please list all current allergies (please print)

Medication Allergies

Medication	Reaction

Other Allergies (food, latex, iodine, etc.)

Substance	Reaction

Patient Signature: _____ **Date:**_____

Past Medical History

Please indicate whether you have had any of the following conditions in the **Past.**

Cardiovascular
- □ Angina
- □ Arrhythmia
- □ Atrial Fibrillation
- □ Congestive Heart Failure (CHF)
- □ Coronary Artery Disease (CAD)
- □ Heart attack
- □ Heart disease
- □ Hypertension (high blood pressure)
- □ Leukemia
- □ Stroke
- □ Other: _____

Endocrine/ Metabolic
- □ Diabetes Mellitus
- □ Gout
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Other: _____

General
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ High Cholesterol
- □ Obesity
- □ Sleep Apnea
- □ Other: _____

Gastrointestinal
- □ Constipation
- □ Crohn's disease
- □ Diarrhea
- □ Diverticulitis
- □ GERD
- □ Hemorrhoids
- □ Irritable Bowel Syndrome (IBS)
- □ Ulcer
- □ Other: _____

OB/GYN
- □ Breast Cancer
- □ Menopause
- □ Menstrual Problems
- □ Osteoporosis
- □ Post-menopausal
- □ Uterine Fibroids
- □ Other: _____

Genital/ Urinary
- □ Bladder Infection
- □ Bladder Stone
- □ Blood in Urine (hematuria)
- □ Decreased sex drive
- □ HIV/AIDS
- □ Human Papilloma Virus (HPV)
- □ Interstitial Cystitis
- □ Kidney Cancer
- □ Kidney Infection
- □ Kidney Stones
- □ Nocturia (urinating at night)
- □ Transplant recipient
- □ Urgency
- □ Urinary Frequency
- □ Urinary incontinence
- □ Urinary Tract Infections (UTI)
- □ Venereal Disease
- □ Vulvar pain
- □ Other: _____

Head/Ears/Eyes/Neck/Throat
- □ Cataracts
- □ Glaucoma
- □ Hay Fever
- □ Sinusitis
- □ Tinnitus
- □ Vertigo
- □ Other: _____

Musculoskeletal
- □ Arthritis
- □ Back Pain
- □ Fibromyalgia
- □ Other: _____

Respiratory
- □ Asthma
- □ Bronchitis
- □ Chronic Obstructive Pulmonary Disease (COPD)
- □ Emphysema
- □ Lung Disease
- □ Pneumonia
- □ Tuberculosis
- □ Other: _____

Neurological/Psychological
- □ Alzheimer's disease
- □ Anxiety
- □ Chronic Fatigue Syndrome
- □ Depression
- □ Migraines
- □ Organic Brain Syndrome
- □ Parkinson's
- □ Schizophrenia
- □ Seizures
- □ Spinal Cord Injury
- □ Stroke
- □ Other: _____

Tumor/Malignancies
- □ Brain Tumor
- □ Breast Cancer
- □ Cervical Cancer
- □ Colon/Rectal Cancer
- □ Fibrocystic Breast Disease
- □ Kidney Cancer
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Metastatic Cancer
- □ Ovarian Cancer
- □ Pancreatic Cancer
- □ Prostate Cancer
- □ Uterine Cancer
- □ Other: _____

Other: _____

_____

_____

_____

_____

_____

_____

Review of Systems (ROS)

General/Constitutional

Please check any symptoms you are currently experiencing:

☐ fever ☐ chills ☐ night sweats ☐ loss of appetite ☐ recent weight loss ☐ recent weight gain ☐ sleep disturbance ☐ weakness

Genitourinary

Please check any symptoms you are currently experiencing:

☐ back/flank pain ☐ bedwetting ☐ blood in urine (hematuria) ☐ dribbling ☐ burning or painful urination ☐ intermitency ☐ kidney infections ☐ kidney stones ☐ voiding at night ☐ not emptying (urinary retention) ☐ slow start ☐ STDs ☐ straining to urinate ☐ urgency ☐ urinary frequency ☐ urine leakage (incontinence) ☐ urinary tract infection ☐ weak stream

Skin

Please check any symptoms you are currently experiencing:

☐ skin rash ☐ skin lumps ☐ itching ☐ dryness ☐ new skin moles ☐ changes in hair or nails ☐ change in size or color of moles ☐ acne

Ophthalmologic

Please check any symptoms you are currently experiencing:

☐ blurred vision ☐ cataracts ☐ changes in vision ☐ double vision ☐ dry eye ☐ glasses or contact lenses ☐ pain ☐ glaucoma

Ears, Nose, Throat

Please check any symptoms you are currently experiencing:

☐ hearing loss ☐ use of hearing aids ☐ ringing in ears ☐ ear infection ☐ vertigo ☐ nasal congestion ☐ hay fever ☐ sore throat

Cardiovascular

Please check any symptoms you are currently experiencing:

☐ chest pain ☐ palpitations ☐ heart murmur ☐ shortness of breath at rest ☐ shortness of breath with activity ☐ swelling ☐ pain in legs with activity ☐ vaicose veins

Respiratory

Please check any symptoms you are currently experiencing:

☐ asthma ☐ bronchitis/emphysema ☐ frequent cough ☐ sputum production ☐ coughing up blood ☐ difficulty breathing ☐ wheezing ☐ painful breathing

Gastrointestinal

Please check any symptoms you are currently experiencing:

☐ abdominal pain ☐ acid reflux ☐ bloody stools ☐ change in bowel habits ☐ constipation ☐ diarrhea ☐ excessive gas production ☐ hemorrhoids ☐ indigestion ☐ jaundice ☐ nausea/vomiting ☐ painful swallowing ☐ rectal bleeding ☐ vomiting blood

Musculoskeletal

Please check any symptoms you are currently experiencing:

☐ arthritis ☐ back pain ☐ gout ☐ joint pain ☐ leg swelling ☐ muscle cramps ☐ muscle weakness ☐ neck pain/stiffness

Neurologic

Please check any symptoms you are currently experiencing:

☐ balance problems ☐ feeling disoriented ☐ difficulty speaking ☐ dizziness ☐ fainting ☐ headache ☐ numbness.tingling ☐ seizures ☐ tremors ☐ weakness/paralysis

Hematology

Please check any symptoms you are currently experiencing:

☐ anemia ☐ aspirin use ☐ easy bruising or bleeding ☐ swollen glands

Endocrine

Please check any symptoms you are currently experiencing:

☐ cold intolerance ☐ excessive thirst ☐ excessive sweating ☐ hair loss ☐ heat intolerance ☐ fatigue/feeling sluggish

Men Only

Please check any symptoms you are currently experiencing:

☐ hernia ☐ lump in groin ☐ penile discharge ☐ scrotal pain or swelling ☐ testicular pain or masses

Women Only

Please check any symptoms you are currently experiencing:

☐ breast lump ☐ heavy bleeding during menstruation ☐ irregular periods ☐ vaginal bleeding not related to menstruation

☐ vaginal discharge

All Other Systems

○ All others negative except as noted

Kasraeian Urology

PAST SURGICAL HISTORY - Please indicate whether and when you have had any of the following surgeries. Use last box in each category to indicate any surgeries not listed.

Cardiovascular

√	Surgery	Approximate Date
	Angioplasty	
	Coronary Artery Bypass Graft (CABG)	
	Pacemaker insertion	
	Stent placement	

General

√	Surgery	Approximate Date
	Brain Surgery	
	Laminectomy	

Gastrointestinal

√	Surgery	Approximate Date
	Appendectomy	
	Bariatric surgery	
	Colon resection	
	Colonoscopy	
	Gall bladder removal (cholecystectomy)	
	Gastric surgery	
	Inguinal hernia repair (groin)	
	Liver transplant	
	Rectal polyp	
	Rectocele repair	
	Umbilical hernia repair (navel)	

Genital/ Urinary

√	Surgery	Approximate Date
	Bladder biopsy (TURBT)	
	Bladder surgery	
	Cystocele repair	
	Cystoscopy	
	Laser lithotripsy/ ESWL	
	Nephrectomy	
	Prostate resection (TURP)	
	Prostatectomy - DaVinci	
	Prostatectomy – laparoscopic	
	Renal transplant	
	Ureteral stent placement	
	Urethral dilation	
	Rectocele repair	
	Prolapse Surgery	
	Urethral Sling	

OB/GYN

√	Surgery	Approximate Date
	Breast surgery	
	Delivery - cesarean	
	Delivery - vaginal	
	Endometrial ablation	
	Hysterectomy (partial)	
	Hysterectomy (total)	
	Lumpectomy of breast	
	Mastectomy	
	Tubal ligation	

Head/ Ears/ Eyes/ Neck/ Throat

√	Surgery	Approximate Date
	Cataract surgery	
	Corneal surgery	
	Deviated septum correction (septoplasty)	
	Eye surgery	
	Sinus surgery	
	Thyroid surgery	

Musculoskeletal

√	Surgery	Approximate Date
	Amputation	
	Back surgery	
	Foot surgery	
	Hand surgery	
	Hip surgery	
	Knee surgery	
	Rotator cuff surgery	
	Shoulder surgery	

Respiratory

√	Surgery	Approximate Date
	Lung surgery	

Skin

√	Surgery	Approximate Date
	Melanoma	

Kasraeian Urology

FAMILY HISTORY - Please indicate whether anyone in your family has had the following conditions including parents, siblings, grandparents, aunts and uncles. ____ **I am adopted and I do not know my family medical history.**

√	Condition	Relative(s) with Condition
	Alcoholism	
	Alzheimer's Disease	
	Arthritis	
	Asthma	
	Bladder cancer	
	Bleeding disorder	
	Breast cancer	
	Cervical cancer	
	Colon cancer	
	COPD	
	Depression	
	Diabetes	
	Glaucoma	
	Gout	
	Heart disease	
	High blood pressure	
	Kidney disease	
	Kidney stones	
	Leukemia	
	Lung cancer	
	Osteoporosis	
	Ovarian cancer	
	Prostate cancer	
	Thyroid disease	
	Uterine cancer	
	Other	

SOCIAL HISTORY

Please indicate the following.

Marital Status / Children

____ Single ____ Widowed ____ # of children
____ Married ____ Separated
____ Divorced ____ Other: _____

Alcohol Consumption

____ None ____ Occasional/Social
____ Yes ____ Drinks per week
____ Beers per Week

Current Tobacco Use

____ None ____ Packs per day
____ Yes ____ Cigarettes per day
____ Smokeless Tobacco
____ Other: _____

Previous Smoking History

____ None How long did you smoke? _____
____ Yes How many cigarettes per day on average? ____
When did you stop? _____

Caffeinated Beverages

____ Low
____ Moderate
____ Excessive
____ Cups of coffee per day: _____
____ Other: _____

Recreational Drug Use

____ None
____ Former User, Please Name Substance _____
____ Current User, Please Name Substance _____
____ Other: _____

Bladder Satisfaction Survey

Patient Name:_____ Date:_____

Which Symptoms best describe you?

☐ Frequent Urination- Day, Night, or Both ☐ Leaking with Sneezing, Coughing, Exercising

☐ Sudden or Strong Urge to Urinate ☐ Leaking with Urge or No warning (unable to make it to the bathroom in time)

☐ Unable to Empty the Bladder ☐ Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? ☐ **Yes** ☐ **No**

If yes, check the medications you have tried:

☐ **Detrol LA** ☐ **Ditropan XL** ☐ **Flomax** ☐ **Cardura**

☐ **Oxytrol Patch** ☐ **Enablex** ☐ **Vesicare** ☐ **DDAVP**

☐ **Sanctura** ☐ **Elavil** ☐ **Elmiron** ☐ **Myrbetriq** ☐ **Toviaz**

☐ **Rapaflo** ☐ **Avodart/Proscar** ☐ **Other:** _____

Did these medications help your symptoms? (Circle #)

1	2	3	4	5	6	7	8	9	10

No Relief **Completely Cured**

If you've stopped taking your meds explain why:

☐ Did not help ☐ Side Effects ☐Too Expensive

Describe Side Effects: _____

Behavior Modifications Tried: _____
(i.e. caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? (Circle #)

1	2	3	4	5	6	7	8	9	10

Not Frustrated **Very Frustrated**

Do you currently have any problems with bowel function? ☐ Fecal Incontinence ☐ Constipation ☐ Other

I am interested in learning more about treatment alternatives to medications: □ Yes □ No

ICIQ Incontinence Questionnaire

Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. Please answer the following questions, thinking about how you have been on average over the **past four weeks**.

1. Are you: □ Male □ Female

2. How often do you leak urine?

   ☐ Never

   ☐ About once a week or less often

   ☐ Two or three times a week

   ☐ About once a day

   ☐ Several times a day

   ☐ All the time

3. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)

   ☐ None

   ☐ Small amount

   ☐ Moderate amount

   ☐ Large amount

4. Overall, how much does leaking urine interfere with your daily life? (Circle a number)

1	2	3	4	5	6	7	8	9	10

Not at all A Great Deal

5. When does urine leak? (Please pick all that apply)

   ☐ Never- urine does not leak

   ☐ Leaks before you can get to the toilet

   ☐ Leaks when you cough or sneeze

   ☐ Leaks when you are asleep

   ☐ Leaks when you are physically active/exercising

   ☐ Leaks when you have finished urinating and are dressed

   ☐ Leaks for no obvious reason

   ☐ Leaks all the time

Kasraeian Urology

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Authorization for the Release of Medical Records:

From: _____

To: _____

Reason for Transfer: _____

Any physician, medical practitioner, hospital, pharmacy, or clinic or other medical or medically-related facility or provider of medical or dental services or supplies.

I authorize you to release and send to Kasraeian Urology a complete copy of any and all of the following information, records or documents related to:

_____ Patients Name (please print)

_____Date of Birth _____ Social Security #

Any and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my continuity of care.

I understand that the information obtained by use of the authorization will be used for the purpose of continuity of medical care only. Any information obtained will not be released by
Kasraeian Urology to any person or organization EXCEPT to referring physicians who have or will be treating me, or other persons or organizations performing business or legal services in connections with my medical treatment, or as may be otherwise lawfully required, or as I may further authorize.

This authorization is given in connection with continuity of medical care. I intend that it be valid for the duration of my treatment.

A photocopy or facsimile of this authorization shall be valid as the original. I know that I may request to receive a copy of this Authorization.

_____ _____
Signature of Patient, Guardian or Power of Attorney Relationship to Patient (If not signed by patient)

_____
Date of signature

KASRAEIAN UROLOGY

OFFICE BUSINESS POLICIES

INSURANCE: Our office accepts most insurance plans and as a courtesy will file your claim. All copayments, coinsurances, and deductibles not covered by insurance will be collected at the time of your visit. For questions regarding non covered services processed by insurance please contact your insurance carrier. For any additional questions or concerns regarding your account with our office, please call our billing department at (904) 727-7955.

HMO PATIENTS: The physicians at Kasraeian Urology are specialist in their field and as such, require referrals from the primary care physician under most HMO plans. Patients have the responsibility of obtaining ta referral before each visit to this office. Patients who do not have a valid referral may be asked to reschedule their appointment.

SELF-PAY PATIENTS: Payment is required at the time of your appointment. Our Front Desk/Billing Department can assist you with any questions regarding our fees.

PRESCRIPTION REFILLS: In order to expedite your refill request, please contact your pharmacy. Calls for refills will be handled Monday thru Friday from 9:00 AM – 12:00 Noon and 1:00 PM – 4:30PM. The office encourages patients to call during these hours and prior to running out of medication at least 48 hours in advance. Prescriptions that require a hand written signature will require an office visit and will not by refilled over the phone.

TEST RESULTS: Under the HIPPA or Healthcare Portability Patient Privacy Act, test results will **NOT** be given or discussed by phone. Results will be discussed at length during your regularly scheduled follow-up appointment. Notification to you by our office of abnormal testing will result in a phone call or letter to you requesting that you make an office visit to discuss these results.

TELEPHONE: for emergencies please dial 911 or proceed to the nearest emergency room or hospital. Routine telephone messages will be reviewed and returned at the end of clinic. If your situation is *"URGENT"*, please notify the office personnel and immediate action will be taken.

SPECIAL REPORTS: Due to the proliferation and length of these reports, we are requesting patients prepay a fee from $25-$75 for these special reports. Charges will be determined by the number of pages processed and the time spent reviewing records. Generally, insurance companies do not cover the fees for preparation of special reports; the responsibility is that of the patient upon delivery of the forms to the office - completion will take 5-10 business days.

COLLECTION FEES/RETURNED CHECK FEES: There will be a $40.00 returned check fee associated for nonsufficient funds. Unpaid returned checks will be forwarded to our collection agency. Any account forwarded to collections will be assessed with a collections fee and collection cost. The patient will be responsible for those fees.

PATIENT SIGNATURE:_____ **DATE:**_____

BY SIGNING THIS FORM, YOU AGREE THAT YOU HAVE READ AND UNDERSTAND THE OFFICE POLICIES AND PROCEDURES AND HAVE HAD AN OPPORTUINTY TO HAVE ANY QUESTIONS REGARDING THESE POLICIES ANSWERED.

KASRAEIAN UROLOGY

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Kasraeian Urology to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Our notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by asking the front desk receptionist for a copy or by calling the office at 904-727-7955.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

I hereby authorize Kasraeian Urology and their medical office staff to release any and all information whether by telephone or written word regarding my medications or health related matters to: (Listed names may include family members, spouse, care givers, individuals with power of attorney, etc.)

1. Name_____ Relation:_____
2. Name_____ Relation:_____
3. Name_____ Relation:_____
4. Name_____ Relation:_____
5. Name_____ Relation:_____

Please note personal information will need to be verified in order to obtain information regarding you as the patient.

Signed: _____ Date: _____

Print Name of Patient: _____

If you are signing as the patient's representative print your name & describe your authority.

(OVER)

KASRAEIAN
UROLOGY

ACKNOWLEDGEMENT

Please sign below indicating you have received or were given the option to receive and declined a copy of Kasraeian urology's Notice of Privacy Practices packet. By signing this document you are agreeing that you understand our Privacy Practices here at Kasraeian Urology.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

LEGAL GUARDIAN/REPRESENTATIVE SIGNATURE:_____

RELATIONSHIP TO PATIENT (If other than patient) _____

WITNESS: _____

DATE: _____

COMMENTS: (For Office Staff Use Only)