

Department of Urology New Patient Intake Form—Female

Last Name _____ First Name _____
 Date of Birth: ____/____/____ Social Security Number: _____
 Referring Physician: _____ Phone #: _____
 Physician Address: _____

History of Present Illness
 Please answer the following questions

Chief Complaint

What is the main reason for your visit today?

- Bladder Cancer
- Urinary Tract Infections
- Renal Cyst/ Mass
- Urinary Frequency
- Other: _____
- Hematuria (Blood in Urine)
- Kidney Stones
- Urinary Incontinence

Which symptoms best describe you? Check all that apply.

- Frequent Urination—day, night, or both
- Sudden or strong urge to urinate
- Leakage with little or no warning----sometimes unable to make it to the bathroom in time
- Unable to completely empty the bladder----feels like there is more even after going to the bathroom
- Accidental leakage with physical activity---exercising, sneezing, or coughing
- Bladder or pelvic pain
- Problems with bowel function (if checked, please select symptom below)
 - Accidental loss or leakage of stool
 - Constipation
 - Other
- No Bladder or bowel problems

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? Yes No

If yes, how many different medications have you tried? _____

On a scale from 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number

0	1	2	3	4	5	6	7	8	9	10
No Relief										Complete Symptom Relief

Are you still taking any of these medications? Yes No

If no, why have you stopped taking them?

- Did not work as well as expected
- Side effects
- Expense
- Interaction with other medications
- Other

If side effects or other checked, please explain: _____

Behavior modifications tried? _____

(I.e., reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

On a scale from 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number

0	1	2	3	4	5	6	7	8	9	10
Not Frustrated										Extremely Frustrated

Urogenital Distress Inventory Short Form (UDI-6)

Please answer each question by checking the best response. While answering these questions, please consider your symptom over the last 3 months. We realize that you may not be having problems in some of these areas, but please fill out this form as completely as possible.

Do you experience, and if so, how much are you bothered by ...	Not at all	Slightly	Moderately	Greatly
Frequent Urination	0	1	2	3
Leakage related to feeling of urgency	0	1	2	3
Leakage related to physical activity, coughing, or sneezing	0	1	2	3
Small amounts of leakage (drops)	0	1	2	3
Difficulty emptying bladder	0	1	2	3
Pain or discomfort in lower abdominal or genital area	0	1	2	3

INCONTINENCE IMPACT QUESTIONNAIRE-SHORT FORM (IIQ-7)

Some people find accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your ...	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Items 1 and 2 = physical activity; Items 3 and 4 = travel
 Items 5 = social/relationships; items 6 and 7 = emotional health

Scoring: Item responses are assigned values of 0 for “not at all,” 1 for “slightly,” 2 for “moderately,” and 3 for “greatly.” The average score of items responded to is calculated. The average, which ranges 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Reference: Uebersax, J.S., Wyman, J.F., Shumaker, S.A, McClish, D.K, Fantl, J.A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory. *Neurology and Urodynamics*, 14(2), 131-139.



Past Medical & Social History

Please answer the following questions

Medical History

Please check if you have ever had any of the following:

- Parkinson's
 - Heart Disease
 - High Blood Pressure
 - High Cholesterol/triglyceride
 - Stroke/TIA
 - Thyroid
 - Cancer: Type _____
 - Kidney/Bladder (Renal Cyst, Renal Mass, Stones)
 - Anxiety, depression or mental illness
 - Blood disorders (abnormal bleeding anemia, high or low white count)
 - Other _____
- Multiple Sclerosis
 - Heart Attack
 - Lung (COPD, Asthma)
 - Sexually transmitted disease
 - Diabetes
 - Seizures/Epilepsy

Are you pregnant? Y / N
 How many Pregnancies? _____ How many children? _____
 Vaginal _____ C-section _____
 Date of last menstrual period: _____

Surgical History

- Have you ever had surgery? Yes No
- Please list approximate dates and reasons for any surgery (including childbirth):

Date	Surgeries
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications

- Please list any prescription medications you are currently taking and their dosages.

Medication Name	Dosage	Reason for taking

Medications cont.

- Please indicate if you are taking of the following over the counter medications:

- Aspirin Tylenol Advil/Motrin/Ibuprofen
- Antacid Laxatives Decongestants
- Antihistamines Vitamins/Mineral Supplements
- Other: _____

Pharmacy

Pharmacy Name: _____
 Pharmacy Address: _____
 Pharmacy Phone Number: _____

Allergies

Do you have any allergies? Yes No
 If yes please specify below:

Social History

Occupation: _____
 Marital Status: Single Married Divorced Widow
 Do you smoke? Yes No
 How much? _____
 Have you smoked in the past? Yes No
 How Long? _____
 Do you drink alcohol? Yes No How Much?
 Beer _____
 Wine _____
 Liquor _____
 Do you drink Caffeine? Yes No How Much?
 Coffee _____
 Tea _____
 Soda _____

Are you on a special diet? Yes No
 If yes please Specify: _____

Family History

Please list all serious illnesses in your immediate family;
 (Example: Diabetes, Cancer, Tuberculosis, Heart disease)
 Mother: Age _____ Living: _____
 Deceased- Cause: _____
 Father: Age _____ Living: _____
 Deceased-Cause: _____
 Sister: _____
 Brother: _____



Review of symptoms

Are you currently having problems with the following? Circle yes (y) or no (N)

Constitutional Symptoms

Fever	Y N
Chills	Y N
Sweats	Y N
Weakness	Y N
Fatigue	Y N

Eyes

Blurred Vision	Y N
Double Vision	Y N
Pain	Y N

Immunologic

Recurrent Fevers	Y N
Recurrent Infections	Y N
Malaise	Y N

Neurological

Confusion	Y N
Numbness/Tingling	Y N
Dizzy Spells	Y N
Headache	Y N

Endocrine

Excessive Thirst	Y N
Too hot/Cold	Y N
Excessive Hunger	Y N

Gastrointestinal

Abdominal Pain	Y N
Nausea/Vomiting	Y N
Indigestion/heartburn	Y N
Diarrhea	Y N

Cardiovascular

Chest Pain	Y N
Palpitations	Y N
Ankle Swelling	Y N

Integumentary

Skin Rash	Y N
Boils	Y N
Persistent itch	Y N
Burns	Y N
Skin Lesion	Y N

Musculoskeletal

Joint pain	Y N
Neck Pain	Y N
Back Pain	Y N

Ears/Nose/Throat/Mouth

Ear Infection	Y N
Sore Throat	Y N
Sinus Problems	Y N

Genitourinary

Urine Retention	Y N
Painful Urination	Y N
Urinary Frequency	Y N
Blood in Urine	Y N

Respiratory

Wheezing	Y N
Frequent Cough	Y N
Shortness of breath	Y N

Hematologic/Lymphatic

Swollen glands	Y N
Blood clotting problems	Y N
Bruising tendency	Y N

Psychologic

Depression	Y N
Anxiety	Y N

Physician Signature: _____

Date: _____



Department of Urology New Patient Intake Form—Female



**Ambulatory Care
Consent and Notice of Privacy Practices
Acknowledgement Form**

Patient Name: _____ Date of Birth: _____
MRN: _____ Enc#: _____

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff. I have been provided a copy of the SBOHCA Joint Notice of Privacy Practices (Notice) and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.
I acknowledge the receipt of the Ambulatory Care Patient Guide on, or prior to this visit.

Signature of Patient or Patient Representative

Print Name of Patient or Personal Representative

Relationship, if signed by person other than Patient

Date _____ Time _____

Signature of Witness

Print Name of Witness

Date _____ Time _____



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**Ambulatory Care
Authorization to Discuss PHI with a Designee**

Patient's Name: _____ Date of Birth: _____
(Please Print Clearly) (Please Print Clearly)

By signing below I hereby give permission to _____
(Name of Physician, Physician Practice or Service Practice)

to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this does not include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Signature of Patient _____

Date _____ Time _____

For Office Use Only

Patient's MRN _____

Date received: _____