Valley Urology, P.C.
John A. Bamberl, D.O.

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(602) 467-0222

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(602) 467-0909

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Address
16620 N 40th Street
Suite E
Phoenix, AZ 85032

Dear New Patient,

I would like to take this opportunity to welcome you to our practice. Enclosed is your registration information, this is mailed to help reduce the time spent in the waiting room. If you have any questions regarding these forms please do not hesitate to call my office. Please try to fill out the form completely so that I have a clear picture of your past treatment or condition. Please bring the forms with you to your appointment. If you do not bring these forms filled out to your appointment there is a chance that your appointment will need to be rescheduled. (**Please do NOT mail.**)

If you have had urological x-rays done in the past year please bring the x-rays to your appointment. (The facility where you had them done will release them to you.)

If you have seen another urologist in the past please contact their office so that your records may be forwarded to our office. These records are important so that I may know the urological treatments you have been given in the past.

If you belong to an insurance company that requires a referral, please have your primary care physician fax a copy to our office in addition to the copy that they have given to you.

Thank you for your time spent on the registration information and I look forward to meeting you at your visit.

Sincerely,

John A. Bamberl, D.O.

Please note the times when Dr. Bamberl is available for office appointments
Mondays – Thursdays – 12:30pm-3:30pm
Fridays -- 9:00am-12:30pm
Please check your upcoming appointment against this schedule.

Visit us at **urologychannel.com/bamberl** or **vasectomy.com**

John A Samberl, DO FACOS
Diplomate in Urological Surgery

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New Patient History **Hematuria**

Name: Date of Birth Referred by:
phone

Initial symptom/reason for visit: Date of Onset:

Previous Surgery or Cystoscopy:

Previous Treatments:

Recent Xray studies?:

Do you have:

Visible blood in the urine? N Y Clots? N Y
Cramping back or abd. pain? N Y Intensity? 1 to 10?___
Relieved by?_______Worsened by?__________
Burning with urination? N Y
Other related pain? N Y
Frequency of urination? N Y times during day____
Urination at night? N Y times_____
Decrease force of stream? N Y
Leakage of urine? N Y Pads? N Y/ number/day____
History of kidney stones? N Y Dates Side

Other related problems?

Exposure to Cancer Causing Agents (Carcinogens)?
Tobacco: Never No, quit date: ______ Yes
Maximum number of cigarettes/ day______
Pipe? Cigars? Chew/Snuff?
Family History of Cancer?
Bladder, ___kidney,___ or prostate disease___?

Past Medical History
General Health?

Illnesses?
Ashma Diabetes Heart Disease
Kidney Disease Pneumonia TB
Other?
Allergies?

Medicines/ dose

Immunizations? (circle) Childhood Adult: Tetanus Flu Pneumonia Other

Past Surgical History Procedure/date

Please complete other side of this form

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Systems Review (Circle all that apply please)

Normal weight: ____ height: ___
Constitutional: fever chills
Eyes: Lenses blurring double spots
Ears: Ringing decreased hearing
Nose/Throat: sinuses swallowing problem
Cardiovascular: Shortness of breath Chest pain Ankle swelling
Calf pain Irregular heart beat
I can climb____ flights of stairs without stopping
Respiratory: Cough Blood in sputum Wheezing
Gastrointestinal: Nausea Vomiting Constipation Diarrhea
Blood in stool belly pain heartburn
Genitourinary: discharge bleeding sexual problems
Musculoskeletal: Pain or stiffness in bones or joints Muscle pain or weakness
Psychiatric: Depression Memory loss Personality change
Neurologic: Numbness Tingling Shooting pains Weakness
Loss of consciousness Seizures
Dermatologic: Rash Itching Growths/changes in moles
Endocrine: Heat or Cold Intolerance Increased Thirst Lack of Energy
Slow healing Thyroid problem
Hematologic/Lymphatic: Increased bruising bleeding node swelling
Allergic/Immunologic: rashes allergie itching hives

Family History: Living/Age Deceased/Age Illnesses
Father
Mother
Brothers
Sisters
Children
Family history of Diabetes, Heart, Kidney, Bladder or Prostate Disease, Bleeding disorders, Cancer?

Social History: (items with an * are optional)
Occupation
Marital Status*
Activity*: I exercise vigorously ___ times per week
I sleep about ___ hours in 24

Diet*: I eat ___ servings of vegetables or fruit per day.
I have red meat ___ times per week; fish ___ times per week
I have salad ___ times per week
I eat fast food ___ and restaurant food ___ times per week.
My favorite food is:______
Alcohol: N Y I have about ____ alcoholic drinks a day
Tobacco N Y Specify if not above
Hobbies*
Recent Foreign Travel*
Religious preference*