LONGWOOD U ROLOGICAL ASSOCIATES, PC

Gary P. Kearney, MD   *Michael C. Kearney, MD*
319 Longwood Avenue, Boston, MA 02115
Tel: (617) 277-0100

PATIENT INFORMATION

SS# ______________________

Your Name ______________________

Your Address ______________________

City, State and Zip Code ______________________

Home Telephone Number ______________________ Work Telephone ______________________

Sex (M) (F)   Date of Birth ______________

Employer's Name ______________________

Employer's Address ______________________

E-Mail address: ______________________

Referring Physician: ______________________Telephone: ______________________

Referring Physician Address: ______________________

Primary Care Physician: ______________________Telephone: ______________________

Primary Care Physician Address: ______________________

Marital Status (M) (S) (W) (D) (Other) ____________   Status: (Employed- Full Time)
(Employed- Part Time) (Not-employed) (Self-Employed (Retired) (Military)
(Full-Time Student) (Part-Time Student) (Not a Student)

Person to Notify in Case of Emergency ______________________Telephone ______________________

Who May We Thank For Referring You?______________________

GUARANTOR INFORMATION

Is the Patient Responsible for the Bill (Y) (N) If no, Guarantor name ______________________

Guarantor Address ______________________Telephone ______________________

Guarantor's SS# ______________________Guarantor's Date of Birth ______________________

Guarantor's Employer ______________________

Guarantor's Business Address ______________________Telephone:______________________

E-Mail address: ______________________

INSURANCE INFORMATION

Please provide your insurance card(s) with this form, and/or complete below:

Subscriber Name ______________________Subscriber SS# ______________________
Name of Insurance ______________________ CoPay Amount______________
Address ______________________
Telephone ______________________ Contact ______________________
Effective Date ______________________ Certificate # ______________________
Group Name ______________________ Group # ______________________

Please read and sign the statements on the reverse side of this form before returning to check-in. We will be pleased to answer any questions that you may have.

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE_____/_______/______ DATE OF LAST PHYSICAL EXAM______/_______/______

LAST NAME________________________ FIRST NAME______________ MIDDLE______________

Social Security No. ________________ DATE OF BIRTH_____/_______/______

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

____

____

____

History of Present Illness

Please answer the following questions

Location of the problem

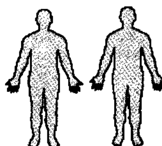
Abdomen Back Leg

Other______________________

____

____

Front **Back**



On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other______________________

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other______________________

How long does the problem last?

30 minutes 1 hour It is always there

Other______________________

Is anything else occurring at the same time?

YES NO If yes, please explain.

Nausea Rash Headaches

Other______________________

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other______________________

Does the problem interfere with your normal functions?

YES NO If yes, please explain____________

____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery **Date**

____

____

____

Do you smoke? **Y** **N**

If yes, how much? ______________

Do you drink? **Y** **N**

If yes, how much? ______________

Are you on any medications? **Y** **N** **(If yes, list all.)**

______________ ______________

______________ ______________

Are you on a special diet? **Y** **N** **(If yes, please explain)**

____

Do you have allergies? **Y** **N** **(If yes, Please explain.)**

____

____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

Pharmacia&Upjohn

(OVER)

UX0006151 July 2000

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Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other___________________

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other___________________

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other___________________

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other___________________

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other___________________

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other___________________

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other___________________

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other___________________

Musculoskeletal

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

Other___________________

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N

Other___________________

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other___________________

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other___________________

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other___________________

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other___________________

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: ______________________ Date: ____/____/____

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International Prostate Symptom Score (I-PSS)[1,2]

Patient's Name ______________________ Date of Birth ______________ Date Completed ______________

	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	
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 2 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 you urinated?	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	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 times or more**	
7. Nocturia Over the past month, how many times did you most typically 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	
						Total I-PSS Score	

	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
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?	0	1	2	3	4	5	6

Adapted with permission from Chatelain C et al, eds.[2]

The International Prostate Symptom Score (I-PSS) is based on the answers to 7 questions concerning urinary symptoms. Each question allows the patient to choose 1 of 6 answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

The International Scientific Committee notes that physicians who counsel men with lower urinary tract symptoms (LUTS) use these measures not only during the initial interview but also during and after treatment in order to monitor treatment response.

The International Scientific Committee, under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the symptoms assessment tool for patients.[3]

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Longwood Urological Associates, PC for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

______________________________ ________________

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Longwood Urological Associates, PC for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

______________________________ ________________

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (HIPAA):

I, the undersigned understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- **A basis for planning my care and treatment**
- **A means of communication among the many health professionals who contribute to my care**
- **A source of information for applying my diagnosis and surgical information to my bill**
- **A means by which a third-party payer can verify that services were actually provided, and**
- **A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.**

I understand and been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.

I wish to have the following restriction to use or disclosure of my health information:

____

____

____

____

I fully understand and accept/decline the terms of this consent.

____

Patient Name Printed

______________________________ ________________

Patient Signature **Date**

LONGWOOD UROLOGICAL ASSOCIATES
Gary P. Kearney, M.D., F.A.C.S.
Michael C. Kearney, M.D.
319 Longwood Avenue
Boston, Massachusetts 02115

Affiliated with
Harvard Medical School

Office (617) 277-0100
Fax (617) 232-7571
www.longwoodurology.com

Managed Care Patients

Your office visit today requires a Referral from your Primary Care Physician

Your claim will be sumbitted to your insurance carrier, but if your Referral has not been received by that time, you will assume financial responsibility for the charges incurred.

Signature: ______________________________

Date: ____________________