PLEASE PRINT ALL PAGES OF THIS DOCUMENT AND FOLLOW YOUR DOCTOR'S OFFICE INSTRUCTIONS.

Please complete these forms.
Reading information and instructions at home
before your visit can benefit you during your office appointment.

If you have questions, please call your doctor's office.

Forms and information provided here are the property of, and
are supplied by, this practice for your convenience
as a service of vasectomy.com.

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Sex: _____ Date: ____/____/____

Patients Name: _____ Age: _____ Birth Date: ____/____/____

Address: _____
Street City State Zip

Home Phone : _____ Social Security #: _____

Employed By: _____ Business Phone: _____

Referred to Doctor By: _____

Reason for seeing Doctor: _____

ALLERGIC TO: _____

INSURANCE INFORMATION

(Please list ALL insurance policies you are covered under)

Cardholder Name: _____ Date of Birth: ____/____/____

Address: _____

Social Security #: _____ Relation: _____

Employed By: _____ Business Phone: _____

Name of Insurance Company(s): _____

BC/BS #: _____

Medicare #: _____

Other Insurance #: _____

Emergency Contact: _____ Phone: _____ Relation: _____
(other than patient's home phone)

Form #128

Urological Surgeons

PATIENT NAME

DATE _____

International Prostate Symptom Score (I-PSS)

	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	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 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 or more times	
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=							

Quality of Life due to Urinary Symptoms

	Delighted	Pleased	Mostly satisfied	Mixed- about equally satisfied and dissatisfied	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

PATIENT SIGNATURE

TOTAL SCORE

Urological Surgeons
44199 Dequindre – Suite 202
Troy, Michigan 48085
248.879.5700

NAME _____ **DATE** _____

DATE OF BIRTH _____ **REFERRED BY:** _____

CHIEF COMPLAINT - Reason for visit:

Medical History Information:

Do you currently have or have you had in the past any of the following?			Please Explain
Cancer	Y	N	If yes, what kind of cancer
Heart disease	Y	N	
Coronary artery disease	Y	N	
Congestive heart failure	Y	N	
Irregular heartbeat	Y	N	
Heart murmur	Y	N	
Mitral valve prolapse	Y	N	
Pacemaker	Y	N	
Peripheral vascular disease	Y	N	
Diabetes	Y	N	
Hypertension	Y	N	
Elevated cholesterol level	Y	N	
Kidney stone	Y	N	
Lump in breast	Y	N	
Lump in scrotum	Y	N	
Stroke	Y	N	
Tuberculosis	Y	N	
Chronic obstructive pulmonary disease (COPD)	Y	N	
Asthma	Y	N	
Hepatitis	Y	N	
Liver disease	Y	N	
Peptic ulcer disease	Y	N	
Thyroid problems	Y	N	
Seizures	Y	N	
Arthritis	Y	N	
Anemia	Y	N	
Cataracts	Y	N	
Glaucoma	Y	N	

Height	Weight

MALE PATIENTS ONLY		FEMALE PATIENTS ONLY			
Date of last prostate exam		Date of last menstrual period			
Most recent PSA result		No. of pregnancies		Live births	

PLEASE LIST ALL ADDITIONAL MEDICAL PROBLEMS	

PLEASE LIST ALL SURGICAL PROCEDURES	YEAR PERFORMED

Social History Information

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

Number of children				
Do you currently smoke cigarettes?	Y	N	How many?	For how long?
Do you smoke cigars/pipe	Y	N		
Do you chew tobacco?	Y	N		
Did you smoke in the past?	Y	N		
If yes, when did you quit smoking?				
Do you drink caffeinated beverages? Coffee – Tea – Soda	Y	N	How many per day?	

Do you drink alcohol?	Y	N	Rarely	Occasionally	Moderately	Heavily

Family History Information

Is there a family history of any of the following?

Cancer	Y	N	If yes, what kind of cancer				
Diabetes	Y	N		Bleeding disorders	Y	N	
High blood pressure	Y	N		Other (please explain)	Y	N	
Heart disease	Y	N					

Review of Systems

Do you have any problems related to the following systems? Circle Yes or No. Please explain any yes answers.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Weight loss	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	Y	N
Tingling	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Feel extremely hot	Y	N
Feel extremely cold	Y	N
Unusually tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Indigestion/heartburn	Y	N

Other _____

Cardiovascular

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

Other _____

Ears/Nose/Throat/Mouth

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

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Blood in urine	Y	N
Urinary incontinence	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 satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N

Other _____

ARE YOU ALLERGIC TO ANY DRUGS? YES NO	If yes, please list

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING	DOSE	HOW OFTEN

ADDITIONAL COMMENTS

PLEASE LIST ALL PHYSICIANS YOU SEE WITH ADDRESS AND PHONE NUMBER

I hereby authorize my insurance company to forward payment of medical benefits to Urological Surgeons. I also authorize Urological Surgeons to release to said insurance company all necessary information required to process my claim.

PATIENT SIGNATURE *(parent or guardian if patient is a minor)* **DATE**