REGISTRATION INFORMATION

Full Name (Last, First, Middle) _____

Present Address _____ Telephone-Home _____
Telephone-Work_____
City _____ State _____ Zip _____ Cellular Phone _____

Social Security No _____ Date of Birth _____

Sex-Male ___ Female __ Marital Status-Single __ Married __ Widowed __ Divorced___

Present Employer _____
Employer's Address & Phone No _____

Spouse's Name (Last, First, Middle) _____
Spouse's Employer _____
Spouse's Employer's Phone No _____

Please name someone that we can contact in case of an emergency or we cannot reach you. (With a phone number different than your own)
Name (Last, First, Middle)_____ _____
Relationship to you _____ Telephone-Home_____
Work_____
Cellphone_____

Referring Physician _____ Telephone No _____
Fax No _____
Family Physician _____ Telephone No _____
Fax No _____

Name of **Primary** Insurance Company _____
Social Security No of the insured _____

Name of **Secondary** Insurance Company _____
Social Security No of the insured _____

If your insurance requires a referral or authorization please make the necessary arrangements to insure it is received at the time of your visit. Thank you.

I authorize Valley Urology, P.C. to release medical information which may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I also assign the claim payment received on my behalf to Valley Urology, P.C. I understand that if a problem should occur with my insurance that it is my responsibility. I understand that if my portion of the bill (co-pays, deductibles, etc.) should lapse more than 90 days it will be referred to a professional collection agency and I will be responsible for any related collection costs.

Signature: _____ **Date:** _____

REGISTRATION INFORMATION

Please list the medications taken on a daily basis

Name of Medication (include dosage and times per day)	Name of Medication (include dosage and times per day)

Please use the back of sheet if more space is needed

Please list all medication that you have an allergic reaction to

Name of Medication (include side effects)	Name of Medication (include side effects)

Please use the back of sheet if more space is needed

Please list all surgeries that you have had in your lifetime

Type of Surgery (include approximate date)	Type of Surgery (include approximate date)

Please use the back of sheet if more space is needed

Please list any known medical problems (i.e. - Arthritis, Diabetes, Hypertension, etc.)

Medical Condition (include approximately how long)	Medical Condition (include approximately how long)

Please use the back of sheet if more space is needed

Have you had any urological testing done in the last year ? (i.e.-Urinalysis, PSA bloodwork drawn) Yes _____ No _____

Have you ever been to see another Urologist? Yes _____ No _____ Urologist's Name _____

If you answered yes to either of these questions please make the necessary arrangements to insure the records are received at the time of your visit. Thank you.

Have you ever had any urological x-rays taken? (i.e. -IVP, KUB, renal Ultrasound, etc.) Yes _____ No _____

If you have had urological x-rays taken please bring the actual films with you to your visit. The hospital or radiology facility will release them to you with your consent.

MALE

NAME _____ PLEASE CIRCLE ONE

My main complaint is: _____

_____

_____

My back hurts in the kidney area _____	Yes	No
It hurts on the right/left side (please circle which side) _____	Yes	No
I have pain below my navel _____	Yes	No
It hurts and burns when I pass urine _____	Yes	No
I pass urine more often than I should _____	Yes	No
I have to wake up at night to urinate _____	Yes	No
I can't hold my urine very long after I get the feeling I need to urinate _____	Yes	No
Sometimes I lose control and wet my pants _____	Yes	No
Sometimes I wet the bed _____	Yes	No
It is hard for me to pass my urine _____	Yes	No
I have to push and strain to urinate _____	Yes	No
It takes longer to pass urine than it should _____	Yes	No
I have had blood in my urine _____	Yes	No
I feel weak and I get tired easily _____	Yes	No
I often run a fever _____	Yes	No
I have lost/gained weight recently (please circle which) _____	Yes	No
My blood pressure has been high _____	Yes	No
My feet, hand or face swell _____	Yes	No

Have you or a close relative been diagnosed for: (please circle one)

Cancer	Yes	No	(If Yes, Relationship) _____
Hypertension	Yes	No	(If Yes, Relationship) _____
Heart Disease	Yes	No	(If Yes, Relationship) _____
Diabetes	Yes	No	(If Yes, Relationship) _____
Arthritis	Yes	No	(If Yes, Relationship) _____
Glaucoma	Yes	No	(If Yes, Relationship) _____
Gout	Yes	No	(If Yes, Relationship) _____
Kidney or Urinary Stones	Yes	No	(If Yes, Relationship) _____
Urological Problems	Yes	No	(If Yes, Relationship) _____
Tuberculosis	Yes	No	(If Yes, Relationship) _____
Hepatitis	Yes	No	(If Yes, Relationship) _____

I have pain in my penis or testicles _____	Yes	No
My penis has a discharge or drip _____	Yes	No
There is swelling in my testicles _____	Yes	No
My penis is swollen _____	Yes	No
My desire for sex is less than it was _____	Yes	No
The desire is there, but I can't carry out the sex act like I used to _____	Yes	No
When my penis gets hard, it hurts _____	Yes	No
My penis bends when it gets hard _____	Yes	No
The hardness fades before I can carry out the act of sex _____	Yes	No
The semen (fluid after intercourse) has been bloody _____	Yes	No
My urinary trouble is worse after intercourse _____	Yes	No
My penis is irritated after intercourse _____	Yes	No

FEMALE

NAME _____ PLEASE CIRCLE ONE

My main complain is: _____

_____

_____

My back hurts in the kidney area _____	Yes	No
It hurts on the right/left side (please circle which side) _____	Yes	No
I have pain below my navel _____	Yes	No
It hurts and burns when I pass urine _____	Yes	No
I pass urine more often than I should _____	Yes	No
I have to wake up at night to urinate _____	Yes	No
I can't hold my urine very long after I get the feeling I need to urinate _____	Yes	No
Sometimes I lose control and wet my pants _____	Yes	No
Sometimes I wet the bed _____	Yes	No
It is hard for me to pass my urine _____	Yes	No
I have to push and strain to urinate _____	Yes	No
It takes longer to pass urine than it should _____	Yes	No
I have had blood in my urine _____	Yes	No
I feel weak and I get tired easily _____	Yes	No
I often run a fever _____	Yes	No
I have lost/gained weight recently (please circle which) _____	Yes	No
My blood pressure has been high _____	Yes	No
My feet, hand or face swell _____	Yes	No

Have you or a close relative been diagnosed for: (please circle one)

Cancer	Yes	No	(If Yes, Relationship)	_____
Hypertension	Yes	No	(If Yes, Relationship)	_____
Heart Disease	Yes	No	(If Yes, Relationship)	_____
Diabetes	Yes	No	(If Yes, Relationship)	_____
Arthritis	Yes	No	(If Yes, Relationship)	_____
Glaucoma	Yes	No	(If Yes, Relationship)	_____
Gout	Yes	No	(If Yes, Relationship)	_____
Kidney or Urinary Stones	Yes	No	(If Yes, Relationship)	_____
Urological Problems	Yes	No	(If Yes, Relationship)	_____
Tuberculosis	Yes	No	(If Yes, Relationship)	_____
Hepatitis	Yes	No	(If Yes, Relationship)	_____

Number of pregnancies _____

Number of live births _____

Date of last pap smear _____

I have pain in my vagina _____	Yes	No
I wet my pants often when I cough, sneeze or laugh _____	Yes	No
I have more than normal vaginal discharge _____	Yes	No
My vagina itches and burns a lot _____	Yes	No
Intercourse is often painful _____	Yes	No
My urinary trouble is often worse after intercourse _____	Yes	No
My desire for sex is less than it was _____	Yes	No