TAUNTON UROLOGIC ASSOCIATES

Affix patient label here

Please complete this general medical information form as completely as possible:

Height:_____ Weight (in pounds):_____ **EMAIL:** _____

Job or previous work:_____

Name of your doctor or doctors:_____
Name of your pharmacy and phone number: _____

Do you have allergies to medications or X-ray intravenous dye? ____Yes ____No If yes, what are you allergic to:_____

Describe your current medical problem or reason for your visit today: _____
_____

List any previous surgery or hospitalizations (Female patients: include number of live births, c-sections, and miscarriages): _____
_____

Do you smoke? ___Yes ____No If no, did you ever smoke? ____Yes ____No
If yes, what do or did you smoke? ____Cigarettes ___Pipe ____Cigars
How many packs a day? _____ How many years have you smoked or did you smoke?_____

Do you drink alcohol? ____Yes ____No If yes, how many drinks a day?_____

Do you use social drugs? ____Yes ____No Do you have HIV or AIDS? ___Yes ____No

Has anyone in your family had: _____Kidney stones ____Cancer ____Diabetes

Are you under a lot of pressure at work or at home? _____Yes _____No

Male Patients: Does/did your father, grandfather, brothers, or uncles have prostate cancer?
_____Yes _____No

Female Patients: Do you use birth control: ___Yes ___No Are you pregnant? ___Yes ___No
Date of last menstrual period:_____ Date of last pap smear: _____

Patient Please Complete Other Side of Form

Review of Systems

Answer the below questions as they relate to your current medical status. Circle Yes or No. Please explain any Yes answers.

Constitutional Symptoms
- Fever Y N
- Other _____

Eyes
- Glaucoma Y N
- Other _____

Allergic/Immunologic
- Drug allergies Y N
- Other _____

Neurological
- Stroke Y N
- Other _____

Endocrine
- Diabetes Y N
- Other _____

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Diarrhea Y N
- Other _____

Pharmaceutical
- Anti-inflammatories Y N
- Aspirin Products Y N
- Coumadin Y N
- Glucophage Y N
- Nitrates Y N
- Plavix Y N

Integumentary
- Skin rash Y N
- Other _____

Musculoskeletal
- Back pain Y N
- Artificial joint replacement Y N
- Other _____

Ear/Nose/Throat/Mouth
- Sinus problems Y N
- Other _____

Genitourinary
- Blood in urine Y N
- Other _____

Respiratory
- Frequent cough Y N
- Shortness of breath Y N
- Other _____

Hematologic/Lymphatic
- Swollen glands Y N
- Bleeding/Blood clotting problem Y N
- Other _____

Cardiovascular
- Chest pain Y N
- Heart Valve Replacement/Prolapse Y N
- Other _____

_____
Medical Provider Signature and Date

TAUNTON UROLOGIC ASSOCIATES
PATIENT MEDICATION LIST

PATIENT NAME_____

DATE_____

MEDICATION	**DOSAGE**	**FREQUENCY**	**DOS & REVIEWER'S INITIALS**

MEDICATION ALLERGIES

_____

_____

_____

_____

_____

DIABETIC YES NO
(please circle one)

LATEX YES NO
(please circle one)

International Prostate Symptom Score (I-PSS)

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	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 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
Quality of Life Due to Urinary Symptoms 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

The International Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms. Each question allows the patient to choose one of six 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). Furthermore, the International Scientific Committee recommends the use of a question to assess the quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of benign prostatic hyperplasia (BPH) symptoms or quality of life, it may serve as a valuable starting point for doctor-patient conversation.

The International Scientific Committee recommends that all physicians who counsel patients suffering from symptoms of prostatism utilize 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 suffering from prostatism.

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NOTICE OF PRIVACY RIGHTS & PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACICES

I received a copy of the Taunton Urologic Associates, P.C. Notice of Privacy Practices.

CONSENT TO TREATMENT

I consent to general treatment, medical procedures, and medications prescribed by my doctor.

FINANCIAL POLICY

I understand my insurance policy is a contract between my insurance company and myself, and that I am ultimately responsible for the entire bill. I understand that the fees are based on treatment received and have no bearing on outcome. I also understand there may be a charge for appointments missed or canceled less than 24 hours prior to my appointment time.

AUTHORIZATION TO PAY FOR PROFESSIONAL SERVICES RENDERED

I hereby authorize payment directly to TUA for professional services rendered,otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by my provider. I understand that I am financially responsible for any professional charges not paid by my insurance company.

CONSENT FOR PAYMENT & COLLECTION COMMUNICATIONS:

I agree that TUA and its agents, including debt collectors, may contact me through the use of any dialing equipment (including a dial-er, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message, even if I am charged for the call or message, for the purpose of servicing my current and future accounts and collecting amounts due.

I agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or mobile service, or any service) I have provided previously or may provide in the future in connection with my account, unless I have requested confidential communications from from TUA and its agents or a restriction on the disclosure of my health care information I accordance with the Notice of Privacy and TUA has agreed to such request. With this consent, I waive any claim I may have against TUA and/or its agents, including debt collectors,for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. 227.

I also agree that this provision applies to the use of text messaging. I consent to the receipt of text messages from TUA and/or its agents, including debt collectors, at any telephone number (including numbers assigned to any cellular or mobile service,or any service) I have provided previously or may provide in the future in connection with my account.

I understand there is a risk of a third-party accessing my health information when communicated over these media. I understand that TUA will continue to use U.S. Mail or regular telephone messaging to communicate with me.

I have read this consent and agree that TUA may contact me as described above.

PLEASE SIGN AND DATE:

SIGNATURE: _____ **DATE:** _____

(See other side)

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS, AND /OR OTHER REPRESENTATIVES

By signing below, I hereby authorize Taunton Urologic Associates, P.C. To disclose my Protected Health Information to the following family members and friends:

NAME	RELATIONSHIP	PHONE #

PLEASE SIGN AND DATE:

Signature _____ **Date** _____

Notice of Privacy & Acknowledgment form given to patient _____