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

BLADDER SATISFACTORY SURVEY

Name_____ Phone #_____

Doctor _____

Which symptoms best describe you?

☐Frequent Urination – Day, Night, or Both
☐Sudden or Strong Urge to urinate
☐Unable to Empty the Bladder
☐Leaking with Sneezing, Coughing, Exercising
☐Leaking with Urge or No Warning (Unable to make it to the bathroom in time)
☐Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? ☐Yes ☐No

If yes, check the medications you have tried:

☐Detrol® LA ☐Ditropan XL® ☐Flomax® ☐Cardura®

☐Oxytrol® Patch ☐Enablex® ☐VESIcare® ☐DDAVP®

☐Sanctura® ☐Elavil® ☐Elmiron® ☐Other_____

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

If you've stopped taking your meds explain why:
☐Did not Help ☐Side Effects ☐Too Expensive

Describe Side Effects _____

Behavior Modifications Tried_____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated **Very Frustrated**

Do you currently have any problems with bowel function?:
☐Fecal Incontinence ☐Constipation ☐Other

I am interested in learning more about treatment alternatives to medications:
☐Yes ☐No

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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)

TAUNTON UROLOGIC ASSOCIATES, P.C.
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TAUNTON, MA 02780

TELEPHONE 508-823-5104 FAX 508-880-7870

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 _____