Scioto Valley Urology, Inc.

500 East Main Street • Suite 220 • Columbus • OH 43215
Phone: (614) 222-3369 Fax: (614) 224-1208

600 N. Pickaway Street • Suite 402 • Circleville • OH 43113
Phone: (740) 420-7882

Dear Patient:

- **Please assist us by *clearly* and *correctly* completing the information.**
- **Please give your insurance card(s) to the receptionist for copying.**

PATIENT	**LAST NAME:**	**FIRST NAME:**	**MI:**	**TITLE:**
ADDRESS:		**CITY:**	**STATE:**	**ZIP:**

GENDER:	**MARITAL STATUS:**	**SOCIAL SECURITY #:**	**DATE OF BIRTH:**
☐MALE ☐FEMALE	☐SIN ☐ MAR ☐SEP ☐DIV ☐WID	________-______-________	/ /
			GUARANTOR'S DATE OF BIRTH: / /

HOME PHONE :	**WORK PHONE:**	**CELL PHONE:**
( ) -	( ) -	( ) -

PREFERRED PHARMACY NAME:	**PREFERRED PHARMACY PHONE NUMBER:**
	( ) -

REFERRING PHYSICIAN	**LAST NAME:**	**FIRST NAME:**	**TITLE** (ex. M.D. / D.O.)

ADDRESS:	**CITY:**	**STATE:**	**ZIP:**	**Phone #:**
				( ) -

PRIMARY CARE PHYSICIAN	**LAST NAME:**	**FIRST NAME:**	**TITLE** (ex. M.D. / D.O.)

ADDRESS:	**CITY:**	**STATE:**	**ZIP:**	**Phone #:**
				( ) -

EMERGENCY CONTACT (1st)	**LAST NAME:**	**FIRST NAME:**	**RELATIONSHIP:**

HOME PHONE :	**WORK PHONE:**	**CELL PHONE:**
( ) -	( ) -	( ) -

EMERGENCY CONTACT (2nd)	**LAST NAME:**	**FIRST NAME:**	**RELATIONSHIP:**

HOME PHONE :	**WORK PHONE:**	**CELL PHONE:**
( ) -	( ) -	( ) -

AUTHORIZATION — **THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.**

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group, or person(s) necessary to secure payment any information needed for this or related Medicare claim. *For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. * The patient or his / her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations, or other services rendered under the general and specific instructions of the physicians. *I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

DATE ______________________ **SIGNATURE X**________________________________

PATIENT (PARENT/GUARDIAN IF MINOR)

Male Medical History

Name: ______________________________________ **Age:** __________ **Date of Birth:** _____/_____/______

Occupation: ____________________________________ **Retired:** ☐ **Yes** ☐ **No** **Race:**_________

Chief Complaint

(What is the **main reason** for your visit today? Write in your own words on the lines provided below.)

History of Present Illness

Location of the problem: (may choose more than one location).	☐ Abdomen ☐ Pelvis ☐ Flank	☐ Back ☐ Penis ☐ Bladder	☐ Groin ☐ Rectum ☐ Thigh
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	☐ One month ago ☐ Other __________________	
Does anything help or make the problem worse?	☐ Moving around ☐ Standing up	☐ Lying on 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? (If yes, please explain).	☐ Yes ☐ No		
Is the problem constant or variable?	☐ Dull then sharp ☐ Very sharp then leaves	☐ Always there ☐ Other ________________	
Does the problem interfere with your normal functions? (If yes, please explain).	☐ Yes ☐ No		

Past Medical History

(**Check** if **yes** only and **circle** if choice provided)

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma or Breathing Problems
☐ Back Pain or Herniated Disk
☐ Bladder or Kidney Infections
☐ Bleeding Problems
☐ Blood Clots or Phlebitis
☐ Bronchitis or Pneumonia
☐ Constipation
☐ Diabetes
☐ Diarrhea
☐ Epilepsy or Seizures
☐ Erectile Dysfunction
☐ GERD (Gastric Reflux)
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis or Liver Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV or AIDS
☐ Kidney Stones
☐ Mental Illness
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Polio
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Urine Incontinence
☐ Bladder Cancer
☐ Colon or Rectal Cancer
☐ Kidney Cancer
☐ Lung Cancer
☐ Penile Cancer
☐ Prostate Cancer
☐ Skin Cancer
☐ Testes Cancer
☐ Other Cancer

Past Surgical History

(**Check** if **yes** only and **circle** if choice provided)

☐ Adenoids or Tonsils Removed	☐ Colonoscopy or EGD	☐ Lung Surgery
☐ Appendix Removed	☐ Cystoscopy	☐ Open Heart Surgery
☐ Back Surgery (Laminectomy)	☐ Gall Bladder (Open vs. Lap)	☐ Pacemaker or AICD
☐ Bladder Surgery	☐ Hernia Surgery	☐ Pilonidal Cyst Removal
☐ Cardiac Catheterization	☐ Hip Surgery (Replacement)	☐ Prostate Surgery
☐ Cardiac Stents	☐ Incontinence Bladder Surgery	☐ Scrotal Surgery
☐ Cataract or Eye Surgery	☐ Kidney Stone Surgery	☐ Varicose Vein Surgery
☐ Circumcision at Birth	☐ Knee Surgery (Replacement)	☐ Vascular Surgery
☐ Circumcision at Later Age	☐ Laparoscopy	☐ Vasectomy

Reason for Hospitalization or Surgery	**Approximate Date of Hospitalization or Surgery**

Medications You Are Currently Taking

☐ **None (If none, please check here)** **Please include: Aspirin, Birth Control Pills, Vitamins, and Herbs**

Medication	**Dosage**	**How Often Taken**

Allergies

☐ **None (If none, please check here)** **Please note if reaction was hives, swelling, or difficulty breathing.**

Medication	**Reaction**

Family History

(**Check** if **yes** only)

	Father	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
High Blood Pressure	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Anesthesia Problems	☐	☐	☐	☐	☐	☐

Social History

Tobacco	**Do you currently smoke?**	☐ **Yes** ☐ **No**
	Did you smoke in the past?	☐ **Yes** ☐ **No**
	If you stopped smoking, what year?	
	Total number of years you smoked:	
	Number of packs smoked per day:	
	Do or did you chew tobacco?	☐ **Yes** ☐ **No**
Alcohol	**Do you drink alcohol?**	☐ **Yes** ☐ **No**
	How much?	
	Do you belong to Alcoholics Anonymous?	☐ **Yes** ☐ **No**
Recreational Drugs	**Drug or Drugs Used:**	☐ **Never** ☐ **Rarely**
	Quantity:	☐ **Occasionally** ☐ **Daily**
		☐ **Discontinued**
Diet and Exercise	**Are you on a special diet?**	☐ **Yes** ☐ **No**
	Do you add salt to your foods?	☐ **Yes** ☐ **No**
	Do you exercise regularly?	☐ **Yes** ☐ **No**
	Does your health restrict you from exercising?	☐ **Yes** ☐ **No**
	Do you use: ☐ **walker** ☐ **cane** ☐ **wheelchair**	

Review of Symptoms

(**Check** if **yes** only and **circle** if choice provided)

Anesthesia:

- History of **malignant hyperthermia**?
  ☐ Yes ☐ No
- Family history of malignant hyperthermia?
  ☐ Yes ☐ No
- Have you had problems with anesthesia?
  ☐ Yes ☐ No
- Had nausea or vomiting after anesthesia?
  ☐ Yes ☐ No

Eyes:

- Do you have trouble with your vision?
  ☐ Yes ☐ No
- Do you have cataracts?
  ☐ Yes ☐ No
- Been told that you have **glaucoma**?
  ☐ Yes ☐ No
- Wear corrective lenses (glasses or contacts)?
  ☐ Yes ☐ No

Ears, Nose, Throat:

- Do you have history of TMJ (jaw) pain?
  ☐ Yes ☐ No
- Do you have difficulty hearing?
  ☐ Yes ☐ No
- Do you wear hearing aides?
  ☐ Yes ☐ No
- Are you frequently bothered by nosebleeds?
  ☐ Yes ☐ No
- Loose teeth/dentures/chipped teeth/caps?
  ☐ Yes ☐ No
- Do you have sinus trouble?
  ☐ Yes ☐ No
- Has your voice been persistently hoarse?
  ☐ Yes ☐ No
- Had bleeding gums often this year?
  ☐ Yes ☐ No
- Had frequent sores on your tongue?
  ☐ Yes ☐ No

Pulmonary:

- Do you have sleep apnea?
  ☐ Yes ☐ No
- If yes, do you use a **CPAP** machine?
  ☐ Yes ☐ No
  (Setting: ____)
- Do you use home oxygen?
  ☐ Yes ☐ No
  (Liters/min: ____)
- Do you have history of asthma?
  ☐ Yes ☐ No
- History of bronchitis or pneumonia?
  ☐ Yes ☐ No
- Do you have a history of tuberculosis?
  ☐ Yes ☐ No
- Been told you have emphysema or COPD?
  ☐ Yes ☐ No

Cardiovascular:

- Have you had episodes of chest pain?
  ☐ Yes ☐ No
- Do you ever experience chest pressure or tightness? ☐ Yes ☐ No
- Do you feel your heart racing in your chest?
  ☐ Yes ☐ No
- Do you take **nitroglycerine** or **nitrates**?
  ☐ Yes ☐ No

- Have you ever had a heart attack?
  ☐ Yes ☐ No
- Do your legs or ankles swell?
  ☐ Yes ☐ No
- Do you have a **pacemaker** or **AICD**?
  ☐ Yes ☐ No
- Are you short of breath with climbing stairs?
  ☐ Yes ☐ No
- Do you have a history of murmur?
  ☐ Yes ☐ No
- Have to take **antibiotics** before dental work?
  ☐ Yes ☐ No
- Do you have a cardiologist?
  ☐ Yes ☐ No
  (Name:)

Gastrointestinal:

- Do you have nausea or vomiting?
  ☐ Yes ☐ No
- Do you have trouble swallowing food or liquids? ☐ Yes ☐ No
- Do you have a history of hiatal hernia?
  ☐ Yes ☐ No
- Have history of stomach or intestinal ulcers?
  ☐ Yes ☐ No
- Have a history of acid reflux or GERD?
  ☐ Yes ☐ No
- Have rectal bleeding or bloody stools?
  ☐ Yes ☐ No
- Have frequent problems with constipation?
  ☐ Yes ☐ No
- Have frequent problems with diarrhea?
  ☐ Yes ☐ No
- Had diverticulosis or had diverticulitis?
  ☐ Yes ☐ No
- Have a history of Crohns disease or colitis?
  ☐ Yes ☐ No
- Gained/lost more than 20 lbs. in six months?
  ☐ Yes ☐ No

Genitourinary:

- Do you have burning upon urination?
  ☐ Yes ☐ No
- Have you ever seen blood in your urine?
  ☐ Yes ☐ No
- Do you have a history of kidney stones?
  ☐ Yes ☐ No
- Have you ever had a urinary tract infection?
  ☐ Yes ☐ No
- Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
- Leak urine when you cough or laugh?
  ☐ Yes ☐ No
- Have urgency or frequency of urination?
  ☐ Yes ☐ No
- Severe urgency that causes urine leakage?
  ☐ Yes ☐ No
- Do you use protective pads daily?
  ☐ Yes ☐ No
  (Number: ____)
- Do you urinate more than 8 times daily?
  ☐ Yes ☐ No

Musculoskeletal:

- Do you often have low back pain?
  ☐ Yes ☐ No
- Do you have swelling of your joints?
  ☐ Yes ☐ No
- Do you have any stiffness of your joints?
  ☐ Yes ☐ No
- Have limitation of motion of your joints?
  ☐ Yes ☐ No
- Have a history of **joint replacement**?
  ☐ Yes ☐ No
- Have a history of rheumatoid arthritis?
  ☐ Yes ☐ No

Integument:

- Do you have hair loss?
  ☐ Yes ☐ No
- Do you have red, dry patches of skin?
  ☐ Yes ☐ No
- Do you have skin ulcers?
  ☐ Yes ☐ No

Neurological:

- Do you often have headaches or migraines?
  ☐ Yes ☐ No
- Have you ever had a seizure or epilepsy?
  ☐ Yes ☐ No
- Numbness or tingling in your arms or legs?
  ☐ Yes ☐ No
- Do you have weakness or paralysis?
  ☐ Yes ☐ No
- Have you had a stroke?
  ☐ Yes ☐ No
- Have you had a TIA (mini stroke)?
  ☐ Yes ☐ No
- Ever fainted or had loss of consciousness?
  ☐ Yes ☐ No
- Ever had a head or spinal cord injury?
  ☐ Yes ☐ No

Psychiatric:

- Do you have difficulty sleeping?
  ☐ Yes ☐ No
- Do you have memory loss?
  ☐ Yes ☐ No
- Do you have mood swings?
  ☐ Yes ☐ No
- Have you ever had an anxiety attack?
  ☐ Yes ☐ No

- Have you ever had hallucinations?
  ☐ Yes ☐ No

Endocrine:

- Do you have excessive hunger?
  ☐ Yes ☐ No
- Do you have excessive thirst?
  ☐ Yes ☐ No
- Have you had problems with infertility?
  ☐ Yes ☐ No

Hematological/Lymphatic:

- Been told you have a low blood count?
  ☐ Yes ☐ No
- Do you bruise easily?
  ☐ Yes ☐ No
- Do you have poor circulation?
  ☐ Yes ☐ No
- Have you ever had blood clots (phlebitis)?
  ☐ Yes ☐ No
- Have you ever had a pulmonary embolism?
  ☐ Yes ☐ No

Allergic/Immunologic:

- Ever had a reaction to a medication?
  ☐ Yes ☐ No
- Any food allergies (peanuts or shellfish)?
  ☐ Yes ☐ No
- Have you ever had hives?
  ☐ Yes ☐ No
- Have seasonal or environmental allergies?
  ☐ Yes ☐ No
- Have you ever had an asthma attack?
  ☐ Yes ☐ No
- Are your immunization shots up to date?
  ☐ Yes ☐ No
- Do you have a **latex** or **rubber** allergy?
  ☐ Yes ☐ No

Have You Ever Been on Any of the Following Medications?

Alpha Blockers:

- Hytrin (terazosin)?
  ☐ Yes ☐ No
- Cardura (doxazosin)?
  ☐ Yes ☐ No
- Flomax (tamsulosin)?
  ☐ Yes ☐ No
- Uroxatral (alfuzosin)?
  ☐ Yes ☐ No

5-Alpha Reductase Inhibitors:

- Proscar (finasteride)?
  ☐ Yes ☐ No
- Avodart (dutasteride)?
  ☐ Yes ☐ No

Anticholinergic Medications:

- Ditropan (oxybutynin)?
  ☐ Yes ☐ No
- Ditropan XL (oxybutynin)?
  ☐ Yes ☐ No
- Detrol LA (tolterodine)?
  ☐ Yes ☐ No
- Oxytrol Patch (oxybutynin)?
  ☐ Yes ☐ No
- Vesicare (solifenacin)?
  ☐ Yes ☐ No
- Sanctura (trospium)?
  ☐ Yes ☐ No
- Enablex (darifenacin)
  ☐ Yes ☐ No

Antibiotics:

- Macrobid (nitrofurantoin)?
  ☐ Yes ☐ No
- Cipro (ciprofloxacin)?
  ☐ Yes ☐ No
- Levaquin (floxacin)?
  ☐ Yes ☐ No
- Proloprim (trimethoprim)?
  ☐ Yes ☐ No
- Bactrim/Septra?
  ☐ Yes ☐ No

Medications for Erectile Dysfunction:

- Viagra (sildenafil)?
  ☐ Yes ☐ No
- Levitra (vardenafil)?
  ☐ Yes ☐ No
- Cialis (tadalafil)?
  ☐ Yes ☐ No
- Caverject (alprostadil)?
  ☐ Yes ☐ No
- Edex (alprostadil)?
  ☐ Yes ☐ No
- Muse (alprostadil)?
  ☐ Yes ☐ No

Medications for Prostate Cancer:

- Zoladex (goserelin)?
  ☐ Yes ☐ No
- Eligard (leuprolide)?
  ☐ Yes ☐ No
- Lupron (leuprolide)?
  ☐ Yes ☐ No
- Vantas (histrelin)?
  ☐ Yes ☐ No
- Casodex (bicalutamide)?
  ☐ Yes ☐ No
- Nilandron (nilutamide)?
  ☐ Yes ☐ No
- Zometa (zoledronic acid)?
  ☐ Yes ☐ No

AUA BPH SYMPTOM SCORE

	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
Incomplete Emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating? 788.21	0	1	2	3	4	5
Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating? 788.41	0	1	2	3	4	5
Intermittency: Over the past month, how often have you found you stopped and started again several times when you urinated? 788.61	0	1	2	3	4	5
Urge to Urinate: Over the past month, how often have you found it difficult to postpone urination? 788.63	0	1	2	3	4	5
Weak Stream: Over the past month, how often have you had a weak urinary stream? 788.62	0	1	2	3	4	5
Straining: Over the past month, how often have you had to push or strain to begin urination? 788.65	0	1	2	3	4	5
	None	1 time	2 times	3 times	4times	5 or more
Urinating at Night: 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? 788.43	0	1	2	3	4	5

Symptom Score: 1-7 Mild, 8-19 Moderate, and 20-35 Severe

Total: ________

BOTHER SCORE DUE TO URINARY SYMPTOMS

	Delighted	Pleased	Satisfied	Mixed	Dissatisfied	Unhappy	Terrible
Bothersome of Urinary Symptoms: How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Over the past 6 months:

SEXUAL HEALTH INVENTORY FOR MEN

How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	No sexual activity	Almost never or never	A few times	Sometimes	Most times	Almost always
	0	1	2	3	4	5
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did not attempt	Almost never	A few times	Sometimes	Most times	Almost always
	0	1	2	3	4	5
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did not attempt	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
	0	1	2	3	4	5
When you attempted sexual intercourse, how often was it satisfactory to you?	Did not attempt	Almost never	A few times	Sometimes	Most times	Almost Always
	0	1	2	3	4	5

Score: If your score is less than 21, you may want to talk to your doctor regarding therapy.

Total: ________