

BROWARD UROLOGY
Elicer Kurzer, M.D., M.P.H.
Michael Simon, M.D.
1951 SW 172 Ave., Suite 300
Miramar, Florida 33029
Tel (954) 499-7696 | Fax (954) 499-7699
www.browardurology.com

PLEASE PRINT CLEARLY

TODAY'S DATE: _____ Email address: _____
LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____
ADDRESS: _____ APT #: _____
CITY: _____ STATE: _____ ZIP: _____
HOME #: _____ CELL #: _____ WORK #: _____
PCP DOCTOR _____ PCP NUMBER _____
CAN WE LEAVE MESSAGES, RESULTS, APPT CONFIRMATION MESSAGES AT THE ABOVE NUMBERS:
PLEASE CIRCLE HOME: YES NO CELL: YES NO WORK: YES NO
PATIENT PHARMACY NUMBER FOR FUTURE MEDICATIONS _____
SS#: _____ DOB: _____ AGE: _____ SEX: _____
MARITAL STATUS (circle one): SINGLE MARRIED WIDOWED DIVORCED
EMERGENCY CONTACT NAME _____ NUMBER _____
EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

IS CONDITION: WORK-RELATED: _____ DATE OF INJURY: _____
AUTO ACCIDENT: _____ DATE OF INJURY: _____
NAME OF ATTORNEY _____
RERESENTING PATIENT: _____ PHONE #: _____

PRIMARY INSURANCE:

SECONDARY INSURANCE:

NAME OF INSURED: _____	NAME OF INSURED: _____
INS CO. NAME: _____	INS CO. NAME: _____
ADDRESS: _____	ADDRESS: _____
CITY: _____ ST: _____ ZIP: _____	CITY: _____ ST: _____ ZIP: _____
PHONE: _____	PHONE: _____
POLICY#: _____	POLICY#: _____
GROUP #: _____	GROUP #: _____

FINANCIAL AGREEMENT:

I AUTHORIZE THE RELEASE OF ANY PAYMENT AND MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND RELATED CLAIMS.

I ALSO UNDERSTAND THAT I AM FINCANCIALY RESPONSIBLE FOR THOSE CHARGES NOT PAID FOR BY MY INSURANCE COMPANY.

I ALSO UNDERSTAND IF THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR OUR ATTORNEY, ALL FEES WILL BE THE RESPONSIBILITY OF THE PATIENT/GUARANTOR.

SIGNATURE: _____ DATE: _____

**Assignment of Benefits/Right to Payment, Patient Responsibility
and Release of Information Form**

21st Century Oncology, LLC
Broward Urology
PO BOX 86215 ORLANDO, FL 32886-2152

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient/Person Legally Responsible

Date: _____

Print Name of Patient/Person Legally Responsible

Relationship to Patient
(If signed by Person Legally Responsible)

**21st Century Oncology, LLC
Broward Urology**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

Signature of Patient or Representative

Date

Print Name

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- Patient/family member received notice but refused to sign acknowledgment
- Emergency treatment situation
- Patient was incapacitated and no family member was present
- Unable to communicate due to language barriers
- Other (please describe below)

Signature of Employee

Date

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number
Address (Street, City, State, ZIP Code)		Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

***DO NOT** discuss or provide information to the following individuals or entities:

Authorized Name	Relationship to Patient	Restricted Name/Entity	Relationship to Patient

*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date
--	------

If Signed by Legal Representative, Relationship to Patient _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

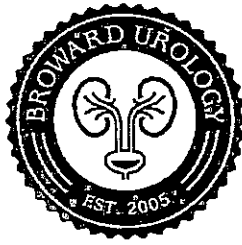
DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted _____ Denied _____

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable _____

Physician Office Representative: _____ Date: _____



Eliecer Kurzer, M.D., M.P.H
Michael Simon, M.D.

Cancellation Policy/No Show Policy For Doctor Appointments and In-office procedures

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty dollar (\$20) cash fee; THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we may have to reschedule the appointment.

3. All account balances are due at time of service

Patients who have questions about their bills may call our office billing department at 786-999-6509 whom they can review their account and concerns.

Print Name Patient

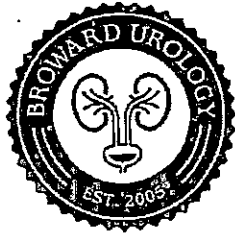
Signature Patient/Guardian

____/____/____
Date

____/____/____
DOB

Patient Account #

(Office Use Only)



Eliecer Kurzer, M.D., M.P.H.
Michael Simon, M.D.

Broward Urology Patient Chart Portal Access

Date: _____

Patient Name: _____ DOB: _____

Dear patient.

In order to have access to your Broward Urology Patient Portal, we require the following information.

Please PRINT your personal email address: _____

Please provide a user name of your choosing: _____

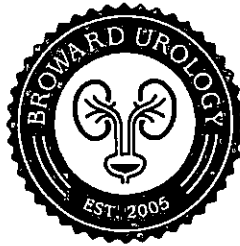
Once your information is entered, an email will be sent to you with instructions on how to log in to.

<https://patientportal.intrinsiq.com/1038>

Please maintain this information in a private safe place. You will be prompted to change your password again in order to gain access. Should you have any questions please feel free to contact us.

Messages and requests sent to your doctor's office are NOT monitored 24/7.
If you are experiencing a medical emergency, you should call 911 immediately.
Results will not be review under the Patient Portal; you must follow up for results.

BROWARD UROLOGY
1951 SW 172 AVE., SUITE 300, MIRAMAR, FL 33029
TEL: 954.499.7696 FAX: 954.499.7699 NURSES STATION FAX: 954.251.5293



Elicer Kurzer, M.D., M.P.H
Michael Simon, M.D.

Notice

This is a private area. You are not authorized to conduct any audio or video recordings on this premises. It is unlawful to conduct any such recordings on this premises under Fla. Stat. § 934.03.

Language to add to consent form:

“By signing hereto, you acknowledge your understanding that I [] does not consent to any audio or video recordings on its premises, and (ii) it is unlawful to conduct any audio or video recordings on this premises under Florida law (pursuant to Fla. Stat. § 934.03). Additionally, by signing hereto you further acknowledge that you will not conduct any audio or video recordings.

Patient Name

DOB

Patient

Signature

Date

**Notice of Privacy Practices
21st Century Oncology, LLC
Broward Urology**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures - How we may use and disclose protected health information about you

For Treatment: We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment: We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:

- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

Law Enforcement / Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Notice of Privacy Practices (Page 2)
21st Century Oncology, LLC
Broward Urology

Other Uses of Your Protected Health Information That Require Your Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at www.21stcenturyoncology.com.

Changes to This Notice

We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679-8944, or by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

For further information, contact:
Privacy Officer
2270 Colonial Boulevard
Fort Myers, FL 33907
1-866-679-8944

Name: _____ Date: _____

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods):

Recent Foreign Travel:
None: _____ Americas: _____ Worldwide: _____

CURRENT MEDICATIONS:
Please list ALL medications you are currently taking including over the counter meds

Drug Name	Strength	Directions/How you take it

(Attach list if necessary)

Pharmacy Name: _____ Phone # _____

By what method did you choose our practice?
____ Referring Physician ____ Friend ____ Yellow Pages ____ Insurance Co. ____ Other

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PATIENT'S NAME: _____ DATE: _____

REVIEW OF SYSTEMS: (Please place a '✓' by all that apply)

<u>Allergic/Immunologic</u>	<u>Ears/Nose/Throat</u>	<u>Genitourinary</u>	<u>Musculoskeletal</u>
<input type="checkbox"/> Seasonal	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Back Pains
<input type="checkbox"/> Drug	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Joint Pains
<input type="checkbox"/> Animal	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Neck pain /stiffness
<input type="checkbox"/> Environmental	<input type="checkbox"/> Other	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Muscle Cramps
<input type="checkbox"/> Other	<u>Endocrine</u>	<input type="checkbox"/> Burning on Urination	<input type="checkbox"/> Arthritis
<u>Cardiovascular</u>	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Erection Problems	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Chest pain/angina	<input type="checkbox"/> Pituitary Disease	<input type="checkbox"/> Premature Ejaculation	<input type="checkbox"/> Other
<input type="checkbox"/> Dyspnea on exertion	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Flank Pain	<u>Neurological</u>
<input type="checkbox"/> Edema	<input type="checkbox"/> Excess thirst	<input type="checkbox"/> Hesitancy	<input type="checkbox"/> Stroke
<input type="checkbox"/> Hardening of the arteries	<input type="checkbox"/> Tired/Sluggish	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Headache
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heat/Cold Intolerance	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Other	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Balance problems
<input type="checkbox"/> Heart Murmur	<u>Eyes</u>	<input type="checkbox"/> Nocturnal Enuresis	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blindness	<input type="checkbox"/> Nocturia	<input type="checkbox"/> Tremors
<input type="checkbox"/> Irregular Heart beat	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Prostate Infection	<input type="checkbox"/> Leg or arm weakness
<input type="checkbox"/> Low exercise tolerance	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Sexual Dysfunction	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Low desire	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Orthopnea	<input type="checkbox"/> Other	<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> Other
<input type="checkbox"/> Pain/cramps w/exercise	<u>Gastrointestinal</u>	<input type="checkbox"/> Stranguria	<u>Psychological</u>
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Suprapubic Pain	<input type="checkbox"/> Not satisfied with life
<input type="checkbox"/> Skipped Heart beats	<input type="checkbox"/> Indigestion/Heartburn	<input type="checkbox"/> Testes/Scrotal Swelling	<input type="checkbox"/> Anxious
<input type="checkbox"/> Swelling	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Urgency	<input type="checkbox"/> Depressed
<input type="checkbox"/> Other	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Considered Suicide
<u>Constitutional</u>	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Urinary Hesitancy	<input type="checkbox"/> Other
<input type="checkbox"/> Aches/Pains	<input type="checkbox"/> Abdominal Cramps	<input type="checkbox"/> Urinary Incontinence	<u>Respiratory</u>
<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bruises easily	<input type="checkbox"/> Constipation	<input type="checkbox"/> Urine Retention	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Fever	<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Urologic Cancer	<input type="checkbox"/> Emphysema/Bronchitis
<input type="checkbox"/> Chills	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Urologic Surgery	<input type="checkbox"/> Environmental Allergies
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Flatulence	<input type="checkbox"/> Vaginal Bleeding	<input type="checkbox"/> Frequent Cough
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Gas	<input type="checkbox"/> Vaginal Discharge/Problems	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Weak Stream	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Generalized Weakness	<input type="checkbox"/> Tarry stools	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Other	<u>Hematological/Lymphatic</u>	<u>Skin</u>
<input type="checkbox"/> Swollen Glands		<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Acne
<input type="checkbox"/> Anorexia		<input type="checkbox"/> Blood clotting problems	<input type="checkbox"/> Boils
<input type="checkbox"/> Weight loss		<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Persistent Itch
<input type="checkbox"/> Weight gain		<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Other		<input type="checkbox"/> HIV (AIDS)	<input type="checkbox"/> Changing moles
		<input type="checkbox"/> IV Drug Use	<input type="checkbox"/> Pigment changes
		<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Other
		<input type="checkbox"/> Other	

Name: _____ Date: _____

PAST MEDICAL HISTORY

Please place a '✓' by any of the following diseases or conditions you have or have had:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Cholelithiasis | <input type="checkbox"/> GERD | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Mitral stenosis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Chronic renal insufficiency | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral insufficiency |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart Valve Problem | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Colon Condition | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Congenital Heart Failure | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pancreatic Cancer |
| <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Aortic Stenosis | <input type="checkbox"/> Deafness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Aortic Insufficiency | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Impaired Glucose | <input type="checkbox"/> tol. Prostate Cancer |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Diabetes—non ins dependent | <input type="checkbox"/> Infertility | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Diabetes—insulin dependent | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Diabetes—uncontrolled | <input type="checkbox"/> Inflam. Bowel Disease | <input type="checkbox"/> Rectal Fissure |
| <input type="checkbox"/> Bi-polar disorder | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rectal Cancer |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sexually Trans. Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Brain tumors | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Laryngeal Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Enlarged Heart | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cholecystitis | <input type="checkbox"/> Gastric Cancer | <input type="checkbox"/> Lymphoma | |

SURGICAL HISTORY:

Please place a '✓' by any of the following surgeries you have had, and include the date of surgery:

Amputation	_____	Facial Surgery	_____	Orchiectomy	_____
Angioplasty	_____	Foot Surgery	_____	Pacemaker Insertion	_____
Aortic Aneurysm Repair	_____	(L or R or both)	_____	Parathyroidectomy	_____
Appendectomy	_____	Gastric Surgery	_____	Penile Implant	_____
Arthroscopic Surgery	_____	Hand Surgery	_____	PEG	_____
Back Surgery	_____	(L or R or both)	_____	Renal Transplant	_____
Bariatric Surgery	_____	Heart Surgery	_____	Rotator Cuff Surgery	_____
Bladder Surgery	_____	Heart Transplant	_____	Septoplasty	_____
Bowel Resection	_____	Hemorrhoidectomy	_____	Sinus Surgery	_____
Brachytherapy	_____	Herniorrhaphy	_____	Skin Grafting	_____
Brain Surgery	_____	Hip Surgery	_____	Spermatoclectomy	_____
Breast Surgery	_____	Hydrocelectomy	_____	Splenectomy	_____
Biopsy of Prostate	_____	Iliioconduit	_____	Stomach Surgery	_____
CABG	_____	Ileostomy	_____	Tonsil Surgery	_____
Carotid Artery Surgery	_____	Indigo Laser Surgery	_____	Thyroid Surgery	_____
Carpal Tunnel Surgery	_____	Inguinal Herniorrhaphy	_____	TMJ Surgery	_____
(L or R or both)	_____	Knee Surgery	_____	TUMT Prostate	_____
Cataract Surgery	_____	(L or R or both)	_____	TUR Prostate	_____
(L or R or both)	_____	Laminectomy	_____	Umbilical Hernia	_____
Cervical Spine Surgery	_____	Laparoscopy	_____	Ureteroscopy	_____
Cholecystectomy	_____	Laparotomy	_____	Varicocelectomy	_____
Circumcision	_____	Leg Surgery	_____	Vasectomy	_____
Colon Resection	_____	(L or R or both)	_____	Vein Stripping	_____
Colonoscopy	_____	Liver Surgery	_____	Ventral Hernia Repair	_____
Corneal Surgery	_____	Lumpectomy	_____	VLAPP	_____
(L or R or both)	_____	Lung Surgery	_____	OTHER NOT LISTED :	_____
Cysto-TUR Fulguration	_____	Lymphatic Node Dissection	_____		_____
Cyst Removal	_____	Lysis Adhesions	_____		_____
Deliveries	_____	Mastectomy	_____		_____
(Vaginal or C-Section)	_____	Mastoid Surgery	_____		_____
Ear Surgery	_____	Meatotomy	_____		_____
(L or R or both)	_____	Nasal Surgery	_____		_____
EGD	_____	Needle Biopsy	_____		_____
Epididymectomy	_____	Nephrectomy	_____		_____
ESWL	_____	Nephrolithotomy	_____		_____
Eye Surgery	_____		_____		_____
(L or R or both)	_____		_____		_____

NAME: _____ Date: _____

FAMILY HISTORY

Please **CIRCLE** which family member has had any of the following: (Mother, Father, or Siblings)

Arthritis	M	F	S	Kidney Stones	M	F	S
Bedwetting	M	F	S	Laryngeal Cancer	M	F	S
Bladder Cancer	M	F	S	Leukemia	M	F	S
Cancer (site unknown)	M	F	S	Malignant Melanoma	M	F	S
Crohn's Disease	M	F	S	Multiple Sclerosis	M	F	S
Depression	M	F	S	Pancreatic Cancer	M	F	S
Diabetes	M	F	S	Prostate Cancer	M	F	S
Gout	M	F	S	Stroke	M	F	S
Heart Attack	M	F	S	Thyroid Disease	M	F	S
Hypertension	M	F	S	Tuberculosis	M	F	S
Kidney Disease	M	F	S	Other:	M	F	S

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years:

Single: _____ Married: _____ Separated: _____ Divorced: _____

Widowed: _____ Life Partner: _____ Common Law Spouse: _____

Dependants: Please indicate # of each, if you have:

Sons: _____ Daughters: _____ Stepchildren: _____ Adopted: _____ Foster: _____

Parents: _____ Grandparents: _____ Other: _____

Occupation: Please place a '✓' by one that applies:

None _____ Laborer _____ Truck Driver _____ Tradesman _____
Clerk _____ Administrative _____ Executive _____ Professional _____
Part-Time _____ Retired _____ Other _____

Hobbies: Please place a '✓' by any that apply to you:

None _____ Golf _____ Tennis _____ Computers _____ Basketball _____
Football _____ Swimming _____ Soccer _____ Baseball _____

Alcohol Consumption:

None _____ Yes - Occasional/Social _____ # of drinks per day _____

Tobacco use per day:

None _____ Yes _____ # packs/day _____ cigarettes/day _____ smokeless tobacco _____
If previously stopped, when? _____

Recreational Drugs:

None _____ If yes, please list: _____

Caffeinated beverages:

None _____ Low _____ Moderate _____ Excessive _____

International prostate symptom score (IPSS)

Name: _____

Date: _____

	Not at all	Less than 1 time in 5	Less than half the	About half the time	More than half the	Almost always	Your score
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
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	
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	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
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	Your score
Nocturia. Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	
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	Deighted	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 the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.