ADVANCED UROLOGY INSTITUTE
240 SOUTHPARK CIRCLE EAST
ST. AUGUSTINE, FL 32086
904-824-1450
HOWARD B. EPSTEIN, MD, FACS

FILL OUT ALL ATTACHED PAPERS AND BRING THEM TO YOUR APPOINTMENT:
ALL PAPERS MUST BE FILLED OUT

APPOINTMENT TIME: ____

APPOINTMENT DATE: ____

On behalf of our entire staff, we would like to take this opportunity to welcome you to our practice and thank you for selecting our office to meet your health care needs. We appreciate the trust you have placed in us.

We are enclosing patient history and information forms for you to complete. Some of these questions may seem unrelated to your problem, however, your cooperation in completing the history form will help us in diagnosing and treating your illness, as well as understanding the relation to other problems you have had.

PLEASE ANSWER ALL QUESTIONS AND BRING THESE FORMS WITH YOU WHEN YOU COME IN FOR YOUR APPOINTMENT.

If you have had any test ordered by another physician (blood work, x-rays, etc.) it is helpful for you to bring the results with you to your appointment. Or, if you prefer, you can call your physician and ask them to fax us a copy of these reports to 904-824-1490. This is important at the time of your initial office appointment as well as for all return visits. Frequently, we can avoid duplicating tests or use the results for comparison. Having the results with you, or having them faxed to us, can save you time and money.

If your insurance plan requires an authorization or referral from you Primary Care Physician, you will be responsible for obtaining this prior to your visit. Co-Payments are due at the time of visit. We accept Medicare assignment; however, you are responsible for any deductible and the difference between Medicare allowable and Medicare payment. We accept most major insurances, but we suggest that you contact your insurance company to verify that our office is a provider for your plan.

A 24-HOUR ADVANCE NOTICE IS REQURED FOR ALL APPOINTMENT AND CANCELLATIONS. FAILURE TO PROVIDE THIS NOTICE MAY RESULT IN A $25.00 FEE.

For your comfort, we suggest you bring a sweater or jacket as our office is sometimes cool. Please bring your insurance card and proof of identification to your appointment.

Thank you for choosing Advanced Urology Institute as part of your health care team.

240 Southpark Circle East
St. Augustine, FL 32086
Phone: (904) 824-1450
Fax: (904) 824-1490

Name:	**Date:**	**Age:**

GENERAL REVIEW OF PERSONAL HISTORY: (a copy of this may be added to your hospital record)

Describe any non-urologic symptoms you presently have:	
Depression or anxiety:	
Neurologic (e.g. weakness, numbness, dizziness, seizures):	
Eyes (glaucoma, double vision):	
Ears, nose, throat, sinuses:	
Endocrine (e.g. diabetes, thyroid trouble)**:**	
Respiratory (e.g. shortness of breath, asthma, bronchitis, bloody sputum):	
Cardiovascular (e.g. angina, palpitations, congestive failure):	
Gastrointestinal (e.g. stomach, intestines, gallbladder, liver):	
Other:	
Are you an "easy bleeder"? ☐ Yes ☐ No	**Have you ever had a blood transfusion?** ☐ Yes ☐ No

List any past operations and approximate dates:			
Operation:	**Date:**	**Operation:**	**Date:**
Operation:	**Date:**	**Operation:**	**Date:**
Operation:	**Date:**	**Operation:**	**Date:**

List any past serious illnesses and approximate dates:			
Illness:	**Date:**	**Illness:**	**Date:**
Illness:	**Date:**	**Illness:**	**Date:**
Illness:	**Date:**	**Illness:**	**Date:**

List all present medications, dosages and reasons for use (include non-prescriptions drugs taken frequently also (e.g. Aspirin)):		
Drug:	**Dose:**	**Reason:**
Drug:	**Dose:**	**Reason:**
Drug:	**Dose:**	**Reason:**
Drug:	**Dose:**	**Reason:**
Drug:	**Dose:**	**Reason:**
Drug:	**Dose:**	**Reason:**

List all allergies, particularly medication and food allergies:	
Allergic to iodine? ☐ Yes ☐ No	**Reaction:**
Allergic to seafood? ☐ Yes ☐ No	**Reaction:**
Allergic to:	**Reaction:**
Allergic to:	**Reaction:**
Allergic to:	**Reaction:**

Do you smoke cigarettes? ☐ Yes ☐ No	**How much per day?**	**How many years?**
Do you ever smoke a pack or more a day? ☐ Yes ☐ No		**How many years?**
Do you drink alcohol? ☐ Yes ☐ No	**Type:** ☐ Wine ☐ Beer ☐ Liquor	**How much a day?**
What is your present or former occupation?		

FAMILY HISTORY

Cancer:	☐ mother ☐ father ☐ brother ☐ sister ☐ grandmother ☐ grandfather
Diabetes:	☐ mother ☐ father ☐ brother ☐ sister ☐ grandmother ☐ grandfather
Nephritis (Bright's disease):	☐ mother ☐ father ☐ brother ☐ sister ☐ grandmother ☐ grandfather
Kidney Stones:	☐ mother ☐ father ☐ brother ☐ sister ☐ grandmother ☐ grandfather
Bleeding Tendencies:	☐ mother ☐ father ☐ brother ☐ sister ☐ grandmother ☐ grandfather
Heart Trouble:	☐ mother ☐ father ☐ brother ☐ sister ☐ grandmother ☐ grandfather
High Blood Pressure:	☐ mother ☐ father ☐ brother ☐ sister ☐ grandmother ☐ grandfather
Other:	

Mother:	☐ living	**Age:**	☐ deceased	**Age of death:**	**Cause of death:**
Father:	☐ living	**Age:**	☐ deceased	**Age of death:**	**Cause of death:**

Sister(s):	**Number living:**	**Age(s):**	
	Number deceased:	**Age(s) at death:**	**Cause of death:**
Brother(s):	**Number living:**	**Age(s):**	
	Number deceased:	**Age(s) at death:**	**Cause of death:**
Children:	**Number living:**	**Age(s):**	
	Number deceased:	**Age(s) at death:**	**Cause of death:**

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Name:

Date:

Age:

Referring Physician:

Have you ever been seen by a urologist? ☐ Yes ☐ No

Urologist's Name:

Symptoms or problems which lead you to seek help:

How many times is your sleep interrupted to urinate?

Do you have pain during urination?

When awake do you urinate:

☐ An appropriate frequency
☐ More often than usual, but not a problem
☐ Enough to be a problem

When you need to urinate do you feel:

☐ You can wait if necessary
☐ You can wait a brief time
☐ You must urinate immediately

How long do you have to wait to start urination after you reach a bathroom:

☐ Not at all
☐ Some delay but not a problem
☐ Enough to be concerned

Do you notice slowing or weakness of your urinary stream?

☐ Not at all
☐ Some but not a problem
☐ Enough to be concerned

Any abnormality in urine such as:

☐ Blood
☐ Cloudy urine
☐ Strong odor to urine

Any pain felt related to urinary tract? ☐ Yes ☐ No

Location:

Describe Pain (e.g. burning, sharp, ache, etc.)**:**

Do you have: ☐ Fever ☐ Chills

Any incontinence (urinary leakage) enough to be a problem?

☐ Yes ☐ No

☐ Get warning but can't wait

☐ Leak without warning (e.g. with coughing, sneezing, laughing)

Check any of the following that apply:

☐ Must strain or bear down to start your urinary system
☐ Intermittent urinary stream
☐ Must return to the bathroom to completely empty your bladder
☐ A history of kidney stones
☐ A history of urinary tract infections
☐ A history of sexually transmitted disease

Have you ever had a catheter or a cystoscopy (procedure where a scope is passed through your bladder) performed? ☐ Yes ☐ No

If yes, when:

FEMALES ONLY (check all that apply)

☐ Menstrual irregularities
☐ Vaginal discharge
☐ Urinary symptoms after intercourse
☐ Post-menopausal bleeding

MALES ONLY (check all that apply)

☐ Pain in testes
☐ Swelling of testes
☐ Pain with ejaculation
☐ Blood in semen
☐ Difficulty obtaining erection, maintaining erection or both

NEW PATIENT OR ANNUAL FEMALE SURVEY

How many times do you typically wake up at night because you have to urinate? ________

Do you typically urinate more frequently than every 2-3 hours during the day? ☐ Yes ☐ No

Do you experience a sudden urge to urinate? ☐ Yes ☐ No

If yes, how often? ☐ Rarely ☐ Occasionally ☐ Frequently

If you postpone urination, will you experience pain? ☐ Yes ☐ No Leakage? ☐ Yes ☐ No

Do you leak urine when you: ☐ Laugh ☐ Cough ☐ Sneeze

If yes, do you wear panty protection? ☐ Yes ☐ No

If yes, what type? ☐ Panty liner ☐ Pad ☐ Undergarment

If yes, typically, how many per day? ________

Is your urine stream typically: ☐ Strong ☐ Weak ☐ Intermittent

Do you have to wait for your stream to start, even though you feel the urge to urinate? ☐ Yes ☐ No

Do you experience pain in your: ☐ Flank area ☐ Lower pelvis

When was your last gynecological exam? _______________

Were you told there were any abnormal findings after your exam? _____________________

Are you currently using any female hormones or creams ☐ Yes ☐ No

REVIEW OF SYSTEMS. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?
PLEASE CHECK THE SYMPTOMS YOU ARE HAVING.

☐ Fever
☐ Chills
☐ Weight Loss
☐ Blurry Vision
☐ Glaucoma
☐ Cataracts
☐ Hearing Loss
☐ Sinus/Congestion
☐ Sore Throat
☐ Chest Pains
☐ Irrregular Heart Beats
☐ Swollen Ankles
☐ Shortness of Breath
☐ Wheezing
☐ Cough
☐ Oxygen Use
☐ Nausea/Vomiting
☐ Diarrhea
☐ Abdominal Pain
☐ Urinary Leakage
☐ Constipation
☐ Blood in Urine
☐ Decreased Libido
☐ Erectile Dysfunction
☐ Chronic Back Pain
☐ Joint Pain
☐ Walks with Cane/Walker
☐ Rashes
☐ Skin Cancer
☐ Current Skin Lesions
☐ Numbness
☐ Tingling
☐ Dizziness
☐ Depression
☐ Panic Attacks
☐ Headaches
☐ Poor Memory

Smoking:

☐ Current Everyday Smoker ☐ Current Somedays Smoker ☐ Former Smoker ☐ Never Smoked

Quit Date: _______________

Language: ________________________

Race: ____________________________

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino