Terrence C. Regan, MD

AUI
ADVANCED UROLOGY
INSTITUTE

We would like to take this time to welcome you to our office as a new patient.

Enclosed are patient information forms for you to complete. Some of these questions may seem unrelated to your problem. However, your cooperation in completing these forms will help us in diagnosing and treating your illness, as well as understanding the relation to other problems you may have had. Please answer **ALL** questions and return the completed forms to our office. Once your forms are received and entered into the computer system, we will contact you to schedule an appointment.

It is important to bring your insurance card and a picture ID with you on the day of your appointment.

We accept Medicare assignment; however, you are responsible for any deductible and the 20% difference between the Medicare allowable and the Medicare payment. Payment of your portion is expected at the time services are rendered. If your insurance plan requires a co-pay, please be prepared to pay it at the time services are rendered.

Please be advised that our office sees patients by appointment only. We do not see walk-in patients. If you feel it is an emergency, please call 911. If you are having an issue that you don't feel is an emergency, please call our office at the number listed below so we can route your message appropriately. All messages are addressed by the next business day.

PLEASE BRING A LIST OF YOUR CURRENT MEDICATION WITH YOU.

Thank you,

Advanced Urology Institute, LLC
Palm Coast

61 Memorial Medical Parkway
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Palm Coast, FL 32164
Phone (386) 445-8530 Fax (386) 446-5087

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Date: _____ Name: _____ DOB: _____

GENERAL REVIEW OF PERSONAL HISTORY: (a copy of this may be added to your hospital record)
Describe any non-urological symptoms you presently have:

Depression or anxiety: _____

Nerologic (e.g. weakness, numbness, dizziness, seizures): _____

Eyes (e.g. glaucoma, double vision): _____

Ears, nose, throat, sinuses: _____

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 operation or immunizations and their approximate dates:
Colonoscopy ❑ Yes ❑ No Date: _____ Pneumonia Vaccine ❑ Yes ❑ No Date: _____

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: _____

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Date: Name: DOB:

List all present medications, dosages and reasons for use (include non-prescription 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 Latex? ❑ Yes ❑ No Reaction: _____
Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____

Smoking Status:

❑ Current everyday smoker ❑ Current someday smoker
How many per day? _____ How many years? _____
❑ Former Smoker – Year quit? _____ How many years? _____
❑ Never Smoker
Do you drink alcohol? ❑ Yes ❑ No Type: ❑ Wine ❑ Beer ❑ Liquor How may per 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: _____
Sisters: number living: _____ age(s): _____
number deceased: _____ age(s) at death: _____ Cause of death: _____
Brothers: 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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Date: Name: DOB:

MUST BE COMPLETED PRIOR TO SEEING THE PROVIDER

Height: _____ Weight: _____

PLEASE CHECK OFF ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE:

- ❑ Fever
- ❑ Chills
- ❑ Weight Loss
- ❑ Blurry Vision
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Hearing Loss
- ❑ Sinus Congestion
- ❑ Sore Throat
- ❑ Chest Pain
- ❑ Irregular Heartbeat
- ❑ Swollen Ankles
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Cough
- ❑ Abdominal Pain
- ❑ Nausea/Vomiting
- ❑ Oxygen use
- ❑ Blood in Urine
- ❑ Diarrhea/Constipation
- ❑ Vaginal Dryness
- ❑ Chronic Back Pain
- ❑ Urinary Leakage
- ❑ Skin Lesions
- ❑ Rashes
- ❑ Erectile Dysfunction
- ❑ Decreased Libido
- ❑ Numbness
- ❑ Joint Pain
- ❑ Walks with Cane/Walker
- ❑ Depression
- ❑ History of Skin Cancer
- ❑ Current Skin Lesion
- ❑ Tingling
- ❑ Dizziness
- ❑ Headaches
- ❑ Panic Attacks
- ❑ Poor Memory

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Date: Name:

DOB: Referring Physician:

Have you ever been seen by a Urologist? ❑ Yes ❑ No Urologists 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 delay but not a problem
❑ enough to be concerned

Any abnormality in urine such as:
❑ blood
❑ cloudy urine
❑ strong odor to urine

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Date: Name: DOB:

Any pain felt related to urinary tract?
❑ Yes ❑ No
Location:_____
Describe Pain (e.g. burning, sharp, ache, etc): _____
_____

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 stream
❑ 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 cystoscopy (procedure where a scope is passed to look at 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
❑ Pain with intercourse

MALES ONLY (check all that apply)

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

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Check the Facts

ABOUT YOUR URINARY ACTIVITIES

NAME AGE

Circle your score for each below.

	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
1 Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2 Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3 Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4 Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5 Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6 Over the past month or so, 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 or more times
7 Over the last month or so, 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

From the American Urological Association (AUA) Symptom Index for BPH.

Total Symptom Score = Sum of Questions 1 to 7 = ____

SYMPTOM SCORE = 1-7 Mild 8-19 Moderate 20-35 Severe

Quality of Life 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?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6