ADVANCED UROLOGY INSTITUTE

ADVANCED UROLOGY INSTITUTE
PATIENT HISTORY FORM

NAME_____ TODAY'S DATE_____ DATE OF BIRTH_____

REFERRED TO OUR PRACTICE BY_____

CHIEF COMPLAINT/ REASON FOR VISIT_____

WHAT PREVIOUS TREATMENT HAVE HOU HAD FOR THIS PROBLEM? By which doctor? _____

_____

HISTORY OF PRESENT ILLNESS: Location of problem: (circle) Abdomen Back Leg Other_____

When did you notice the problem (Circle) 2 days ago 2 weeks ago 1 month ago Other_____

What helps/makes the problem better or worse: (circle) Moving around Standing up Lying on side Other_____

How long does the problem last? (Circle) 30 minutes 1 hour It is always there Other_____

Is the problem constant or variable? (Circle) Dull then sharp Very sharp then leaves Always there Other_____

Does the problem interfere with normal functions? (Circle) Yes No If yes explain_____

UROLOGICAL HISTORY

Do you now have or ever had any of the following?

Kidney stones ( ) NO ( ) YES Comments_____
Frequent urination ( ) NO ( ) YES _____
Trouble starting stream ( ) NO ( ) YES_____
Pain/burning with urination ( ) NO ( ) YES_____
Difficulty holding urine (urgency) ( ) NO ( ) YES_____
Incomplete emptying of bladder ( ) NO ( ) YES_____
Ever had kidney x-rays? ( ) NO ( ) YES_____

Blood in urine ( ) NO ( ) YES Comments_____
Urinate more than 2 x night ( ) NO ( ) YES_____
Decrease size/force of stream ( ) NO ( ) YES_____
Kidney/bladder infection ( ) NO ( ) YES_____
Loss of urine with coughing/sneezing. ( ) NO ( ) YES_____
Gonorrhea/ Syphilis/Herpes ( ) NO ( ) YES _____
Bedwetting as a child? ( ) NO ( ) YES_____

MALES ONLY:
Scrotal Swelling ( ) NO ( ) YES _____
Difficulty with erection ( ) NO ( ) YES
Erections firm for vaginal penetration ( ) NO ( ) YES

Discharge from or sore on penis ( ) NO ( ) YES_____
Are you sexually active? ( ) NO ( ) YES
Do you lose erection during intercourse? ( ) NO ( ) YES

Please complete your most current medication list:

Name of Medication/Over the counter meds/Vitamins/Herbal meds	Strength	# of Times Taken per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

LIST YOUR PHARMACY NAME AND LOCATION:_____

ALLERGIES TO ANY MEDICATIONS OR FOODS OR IV CONTRAST/X-RAY DYE:_____

_____

PAST MEDICAL HISTORY: (CHECK all that apply to you)

( ) High blood pressure
( ) Diabetes
( ) Heart Attack
( ) Stroke
( ) Atrial fibrillation (irregular heart rate)
( ) Arthritis
( ) Glaucoma
( ) hypothyroid
( ) Kidney stones
( ) Cancer: Type:_____
( ) Enlarged prostate (BPH)
( ) Erectile dysfunction
( ) Kidney failure
( ) High cholesterol
( ) Emphysema (COPD)
( ) Asthma
( ) sleep apnea
( ) Mitral valve prolapse
( ) Blood clot in legs (DVT)
( ) Anemia
( ) chronic back pain
( ) Depression/Anxiety
( ) Neurologic problem

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE _____

_____

PREVIOUS SURGERIES:

( ) Appendectomy
( ) Gall Bladder/Cholecystectomy
( ) Tonsillectomy
( )Heart Surgery
( ) Joint replacement surgery: Type:_____
( ) Pacemaker or AICD defibrillator
( ) Kidney stone surgery: Type:_____
( ) Prostate surgery: Type:_____
( ) Bypass surgery (CABG)
( )Kidney surgery
( ) Hysterectomy
( ) Hernia repair
( ) Bladder surgery: Type:_____
( ) Heart Valve surgery
( ) colon/bowel surgery

OTHER SURGERIES NOT LISTED ABOVE_____

_____

FAMILY HISTORY: Has anyone in your family had? (Circle if yes) Prostate Cancer Kidney Stones Kidney Cancer bladder cancer

Is your mother living? YES NO If NO, year deceased_____ Age at death_____

Is your father living? YES NO If NO, year deceased_____ Age at death_____

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SOCIAL HISTORY:

TOBACCO/ ALCOHOL USAGE:

Do you smoke cigarettes? YES NO How many packs per day? _____

If NO, have you ever smoked? YES NO When did you quit? _____

Do you drink alcohol? Never Occasional Daily # Drinks per day_____

ARE YOU : ___MARRIED ___DIVORCED ___SINGLE (NEVER MARRIED) ___WIDOWED

Number of Children?_____

What do you do for work?_____ ( ) Retired ( ) Disabled

REVIEW OF SYSTEMS: Please check Yes or No

General/Constitutional
- Headache ( ) Yes ( ) No
- Chills ( ) Yes ( ) No
- Fever ( ) Yes ( ) No

Opthalmologic
- Blurring of vision ( ) Yes ( ) No
- Double vision ( ) Yes ( ) No
- Eye Pain ( ) Yes ( ) No
- Glaucoma ( ) Yes ( ) No

HEENT/Neck
- Ear Infection ( ) Yes ( ) No
- Sinus Problems ( ) Yes ( ) No
- Sore Throat ( ) Yes ( ) No

Endocrine
- Excessive thirst ( ) Yes ( ) No
- Too hot/too cold ( ) Yes ( ) No
- Fatigue ( ) Yes ( ) No

Respiratory
- Cough ( ) Yes ( ) No
- Shortness of Breath ( ) Yes ( ) No
- Wheezing ( ) Yes ( ) No

Cardiovascular
- Chest Pain ( ) Yes ( ) No
- High Blood Pressure ( ) Yes ( ) No
- Varicose Veins ( ) Yes ( ) No

Gastrointestinal
- Abdominal Pain ( ) Yes ( ) No
- Heartburn/Indigestion ( ) Yes ( ) No
- Nausea/Vomiting ( ) Yes ( ) No

Urologic
- Urinary Retention ( ) Yes ( ) No
- Painful Urination ( ) Yes ( ) No
- Urinary Frequency ( ) Yes ( ) No

Neurologic
- Dizziness ( ) Yes ( ) No
- Numbness/Tingling ( ) Yes ( ) No
- Tremor ( ) Yes ( ) No

Musculoskeletal
- Neck pain ( ) Yes ( ) No
- Back pain ( ) Yes ( ) No
- Joint pain ( ) Yes ( ) No

Dermatologic
- Boils ( ) Yes ( ) No
- Itching ( ) Yes ( ) No
- Rash ( ) Yes ( ) No

Hematology
- Swollen Glands ( ) Yes ( ) No
- Blood Clotting problem ( ) Yes ( ) No

Psychiatric
- Insomnia ( ) Yes ( ) No
- Anxiety ( ) Yes ( ) No
- Depression ( ) Yes ( ) No

COMMENTS: _____

_____

_____

Please fill out if any issues with urinating:

(AUA Symptom Score) In the past month:	Not at all	<1 in 5 times	< ½ times	About ½ the time	> ½ times	Almost always	Your score
How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
How often have you had to urinate less than every 2 hours?	0	1	2	3	4	5	
How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
How often have you had a weak urinary stream	0	1	2	3	4	5	
How often have you had to strain to start urination	0	1	2	3	4	5	
How many times did you typically get up at night to urinate?	0 times	1 time	2 times	3 times	4 times	5 times	
TOTAL SCORE: 1-7 mild; 8-19 moderate; 20-35 severe	///////	///////	///////	///////	///////	//////	

If you were to spend the rest of your life with your current urinary condition just the way it is now, how would you feel about that?

Circle your response: DELIGHTED----PLEASED----MOSTLY SATISFIED----MIXED----MOSTLY DISSATISFIED----UNHAPPY----TERRIBLE

FOR MEN ONLY (SHIM SCORE): **( ) Please check here if you are not sexually active**

CIRCLE the number that best describes your own situation. Select only 1 answer for each question.

Over the past 6 months:	1	2	3	4	5
How do you rate your confidence that you could get and keep an erection?	Very low	low	moderate	high	Very high
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
SCORE (If < 21, speak to your doctor):	//////////	//////////	//////////	//////////	//////////

BayCare
Health System

Electronic Medical Records

Details About Your Health Information in BayCare eHX and the Consent Process:

1. **How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX only:
   - To provide you with medical treatment and related services
   - To check whether you have health insurance and what it covers
   - To evaluate and improve the quality of medical care provided to all patients
   - For administrative management of the BayCare eHX
2. **What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access ALL of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
   - Substance abuse
   - HIV/AIDS
   - Psychiatric/mental health conditions
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Sexually transmitted diseases
3. **Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
4. **Who May Access Information About You, If You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
5. **Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
6. **Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
7. **Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.
9. **Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.

BayCare Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange (BayCare eHX) is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

☐ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

☐ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

_____ _____ _____

Printed Name of Patient/Representative Signature of Patient/Representative Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____