NEW PATIENT INTAKE AND HISTORY FORM
(Please print)

Today's Date: ___________________
Name: ____ **Date of Birth:** ____________________

Local Pharmacy: ____
(Name/City/Phone #)
Mail Order Pharmacy: ____
(Name/City/Phone #)
Reason for today's visit: ____
How long have you had this problem? ____
What improves or worsens the problem/pain? ____
Are there any symptoms that go along with the problem/pain? ____
Is the problem/pain continuous? ____
Have you tried any medicine/treatment for this problem/pain? _______________________________________

PROBLEM LIST / PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ AIDS/HIV	___ Depression	___ Infertility, female	___ Rheumatoid arthritis
___ Alzheimer disease	___ Diabetes	___ Infertility, male	___ Scleroderma
___ Asthma	___ Diverticulitis	___ Irritable bowel synd.	___ Seizures
___ Atrial fibrillation	___ Emphysema, comp.	___ Kidney failure	___ Sleep apnea
___ Bladder stones	___ Erectile dysfunction	___ Kidney stones	___ Spina bifida
___ BPH	___ Fibromyalgia	___ Leukemia	___ STD
___ Cancer of bladder	___ GERD	___ Lupus	___ Stroke
___ Cancer of breast	___ Glaucoma	___ Lymphoma	___ TB (tuberculosis)
___ Cancer of kidney	___ Heart attack	___ MS (mult. sclerosis)	___ Ulcerative colitis
___ Cancer of prostate	___ Hepatitis	___ Osteoporosis	___ Ureter stones
___ Cancer of testis	___ High blood pressure	___ Parkinson's	___ Urine leakage
___ Cirrhosis	___ High cholesterol	___ Peptic ulcer	
___ Congestive heart failure	___ Hyperthyroid	___ Prostate enlargement	
___ COPD	___ Hypothyroid	___ Rheumatic fever	

___ Other: ____

ALLERGY HISTORY:

☐ **No Known Allergies** ☐ **NKDA (No Known Drug Allergies)**

___ Adhesive tape	___ Bactrim	___ Iodine	___ Levaquin	___ Penicillin
___ Ampicillin	___ Cipro	___ Latex	___ Macrodantin	___ Sulfa drugs

Other: ____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, supplements, and herbals that you are currently taking:

Name of Medication	Strength	How Often

PAST SURGICAL HISTORY:

Have you had any of the following surgeries or procedures?

___ Appendectomy	___ Coronary Art. Bypass Graft	___ Hernia Repair	___ Lithotripsy
___ Bladder Surgery	___ Cystocele Repair	___ Hysterectomy	___ Ovarian Resection
___ Bladder Tumor Resection	___ Defibrillator Implant	___ Joint Replacement	___ Prostate Surgery
___ Card. Pacemaker Insertion	___ Gallbladder Surgery	___ Kidney Stone Surgery	___ Prostatectomy
___ C-Section	___ Heart Stent Procedure	___ Kidney Surgery	___ Rectocele Repair
___ Colon/Bowel Surgery	___ Heart Valve Surgery	___ Laparoscopy	___ Vasectomy

___ Other: ____

FAMILY HISTORY:

Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Mother	Father	Sister	Brother
Asthma				
Bladder Cancer				
Bleeding Disorder				
Diabetes				
Heart Disease				
Kidney Disease				
Kidney Stones				
Prostate Cancer				
Renal/Kidney Cancer				
Other:_______________				

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Most recent primary occupation: ☐None ☐ ______________________________

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Current every day smoker
☐ Current some day smoker ☐ Former smoker ☐Never smoker ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐ Yes ☐ No
If yes, please indicate what type of beverage and how many servings per day: ______________________

Have you ever used any illicit drugs? ☐ Yes ☐ No
If yes, please indicate what type of drug and how often: ______________________

Do you have a history of sexually transmitted diseases (STD)? ☐ Yes ☐ No
If yes, please indicate what STD(s): ______________________

PREGNANCY HISTORY: (If applicable)

List number of pregnancies you have had: ____________

List number of deliveries: ____________ **of these, number of C-section (Cesarean):** _________

Have you had a hysterectomy? ☐ Yes ☐ No If yes, please indicate type : ☐ Vaginal ☐ Abdominal

Are you in Menopause? ☐ Yes ☐ No

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it.

General: ☐Normal
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue

Skin: ☐Normal
- ☐ Rash

HEENT: ☐Normal
- ☐ Hearing Loss

Neck: ☐Normal
- ☐ Swollen Glands

Respiratory: ☐Normal
- ☐ Frequent Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Gastrointestinal: ☐Normal
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting

Cardiovascular: ☐Normal
- ☐ Irregular Heartbeat
- ☐ Chest Pain
- ☐ Leg Pain and/or Swelling

Genitourinary: ☐Normal
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Incontinence
- ☐ Painful Urination

Musculoskeletal: ☐Normal
- ☐ Bone Pain
- ☐ Joint Pain
- ☐ Muscle Pain

Neurological: ☐Normal
- ☐ Dizziness
- ☐ Weakness/ Numbness
- ☐ Tremor

Psychiatric: ☐Normal
- ☐ Anxiety
- ☐ Depression

Endocrine/Glands: ☐Normal
- ☐ Excessive Thirst

Hematology: ☐Normal
- ☐ Blood Clots
- ☐ Easy Bruising

Diane Hartman, M.D.
David Cahn, M.D.
Derek Zukosky, D.O.
Thomas Facelle, M.D.
Jeremy Reese, M.D.

400 Indiana Street, suite 300 • Golden, Co 80401
Phone: (303) 985-2550 • Fax: (303) 985-2586

Patient Registration

Date:__________

Patient Information

First Name ______________________ Middle Initial _____ Last Name ______________________

Address ______________________ City ______________ State ________ Zip __________

Primary Contact Number (________) ______________ Alternate Contact Number (_______) ______________

Date of Birth ____/____/____ Marital Status ______________ Sex: Male Female

Social Security Number ______-_____-______ E-Mail Address ______________________

Race ______________ Ethnicity ______________ Preferred Language: ______________

Employment Status: (circle one) Retired Full time Part time Unemployed Self-Employed Student

Occupation ______________________ Employer ______________________

Emergency Contact Person ______________ Relationship ______________ Work Telephone (__) __________

May we release medical information to your emergency contact person? (Circle one) Yes No

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☐ Responsible Party (if different from patient) ☐Court Appointed Guardian

First Name ______________________ Middle Initial _____ Last Name ______________________

Address ______________________ City ______________ State ________ Zip __________

Primary Contact Number (______) ______________ Alternate Contact Number (_______) ______________

Date of Birth ____/____/____ Social Security Number ______-______-______ Sex: Male Female

Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired Full time Part time Unemployed

Occupation ______________________ Employer ______________________

Medical Information

Referring Physician ______________________ Address/Phone ______________________

Primary Care Physician ______________________ Address/Phone ______________________

Pharmacy ______________________ Phone Number (________) ______________

Is this appointment Workman's Compensation: Yes No Claim # ______________

Insurance Information

Primary Insurance ______________________ Subscriber's Name ______________________

Relationship to Policyholder (circle One) Self Spouse Child Other Subscriber's Date of Birth ____/____/____

Policy ID # ______________________ Group # ______________________

Secondary Insurance ______________________ Subscriber's Name ______________________

Relationship to Policyholder (circle one) Self Spouse Child Other Subscriber's Date of Birth ____/____/____

Policy ID # ______________________ Group # ______________________

☐ **Insurance information provided:** I hereby authorize Foothills Urology, P.C. to release necessary medical information to my insurance company (ies). I further authorize direct payment to the above entities from the above listed companies. I understand that I am responsible for obtaining referrals, if necessary, and paying any co-payments, coinsurance, or deductibles required by my Plan. I also understand that I may be responsible for the full amount in event of non-coverage determined by my Plan. If my account is not paid when due, I further agree to pay collection expenses of 25% of the balance plus interest accrued after 90 days at 1.5% monthly.

☐ **No insurance information provided:** I agree to pay in full by cash, check, credit card or money order at or before the date of service, unless I qualify for financial assistance. If my account is not paid when due, I further agree to pay collection expenses and or attorney fees in the amount of 25% of the balance due, plus interest of 1.5% per month on any balance outstanding for 90 or more days.

Service will be provided only if financial arrangements are made at or before the time of service.

Patient/Guardian Signature: ______________________ Date __________

Diane Hartman, M.D.
David Cahn M.D.
Derek Zukosky D.O.
Thomas Facelle M.D.
Jeremy Reese M.D.

HIPAA RELEASE OF INFORMATION FORM

PATIENT NAME:______________________________ DOB:______________________________

IS IT OKAY FOR US TO LEAVE TEST RESULTS AND/OR CONFIDENTIAL MEDICAL INFORMATION ON YOUR VOICEMAIL?

YES OR NO:____________ PHONE # ______________________________

PRIVACY REGULATIONS REQUIRE US TO HAVE RELEASES SIGNED BY OUR PATIENTS TO US TO SPEAK WITH FAMILY MEMBERS, FRIENDS, OR OTHER RELATIONS REGARDING MEDICAL TREATMENT. EACH PERSON MUST BE LISTED INDIVIDUALLY AND BY NAME.

PLEASE PRINT NAME, RELATIONSHIP, AND TELEPHONE NUMBER FOR EACH PERSON TO WHOM YOU ARE AUTHORIZING RELEASE OF YOUR PRIVATE HEALTH CARE INFORMATION.

NAME ______________________ RELATIONSHIP ______________ PHONE # ____________

NAME ______________________ RELATIONSHIP ______________ PHONE # ____________

NAME ______________________ RELATIONSHIP ______________ PHONE # ____________

NAME ______________________ RELATIONSHIP ______________ PHONE # ____________

NAME ______________________ RELATIONSHIP ______________ PHONE # ____________

PATIENT SIGNATURE ______________________________ DATE ____________________

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We wish to welcome you as a new patient to Foothills Urology, P.C. We provide comprehensive services to our patients and we strive to be available to assist you at all times.

Office Policy

* All copays are due at the time of service, and bring your insurance card to all visits. If you do not have insurance, payment for services rendered are due at the time of your visit. We accept Visa, and MasterCard.

* Please notify the front desk if you have any changes to address, phone number, or insurance.

* Bring a complete list of medications, dosages, and medication allergies. Please include all herbals and supplements.

* Please be prepared to provide a urine sample at the time of your visit.

* **CLINICAL APPOINTMENTS - $50 FEE MAY BE CHARGED IF; -OR-**

* **PROCEDURAL APPOINTMENTS - $100 FEE MAY BE CHARGED IF;**

* **YOU ARE 20 MINS LATE PAST APPOINTMENT TIME**

* **NO SHOW**

* **OR CANCEL WITH LESS THAN 24 HOUR NOTICE**

* If a new patient appointment is cancelled twice, we will not reschedule you with any of our providers

* A copy of our notice of privacy practices is located online at www.foothillsurology.com, under the download patient forms tab.

I acknowledge and understand the above office policy. Date _______

Patient or Representative Signature ____________________________

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To serve you with your medical needs, we need you to furnish the following item(s) upon arrival to our office.

_____ **INSURANCE CARD(s) and CO-PAYMENT** if applicable.

_____ **COMPLETE REGISTRATION and MEDICAL HISTORY FORMS.** Do not mail them to us, but bring them with you to your appointment.

_____ **REFERRAL INFORMATION FROM YOUR PRIMARY CARE PHYSICIAN** if applicable. Please obtain the referral prior to your appointment. Lack of referral may require rescheduling of your appointment.

_____ **LAB REPORTS.** (Urinalysis, urine cultures, PSA's [current and prior], kidney function tests, 24 urines) if not drawn Foothills Urology, P.C.

_____ **RADIOLOGIC FILMS and REPORTS** (IVP's, renal US, CT [Urologic] Bone Scans, KUB's) if not performed by Foothills Urology, P.C.

IF YOU ARE UNABLE TO OBTAIN YOUR REPORTS PLEASE CALL OUR OFFICE.

BRING A COMPLETE LIST OF MEDICATIONS, DOSAGES AND MEDICATION ALLERGIES – PLEASE INCLUDE ALL HERBALS AND SUPPLEMENTS.

PLEASE BE PREPARED TO GIVE A URINE SAMPLE AT TIME OF VISIT.

You are scheduled with Dr. ____

On ______________________________ At __________ AM. PM.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date of ______________________________.

Patient or Patient Representative Signature ______________________________

Relationship to Patient ____________________ **Date** ____________________

_____ Patient refused to sign _____ Patient unable to sign because ______________________________

We bill your insurance carrier(s) from our business office when we are contracted with your carrier including Medicare and Medicare Supplement Insurance.

If we are not contracted with your carrier, we ask that you pay for your care at the time service is rendered and we will provide you with a form you may use to bill your insurance. Visa, MasterCard and Discover are accepted. Our Billing Office is available to arrange payment plans or assist you with any questions you may have about your bill.

International Prostate Symptom Score (IPSS)

Patient Name: ______________________ **Today's Date:** ______________________

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – 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?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = ______

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6
Have you tried medications to help your symptoms?						Yes	No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief ... *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

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