Academic Urologist at Erlanger

Erlanger East Office
1755 Gunbarrel Road, Ste 209 Chattanooga, TN 37412

Erlanger Main Campus
979 E 3rd St Ste C535
Chattanooaga, TN 37403

Spring Creek Office
961 Spring Creek Rd, Ste 202 Chattanooga, TN 37412

PATIENT REGISTRATION FORM

Today's date:		Primary Care Physician:			
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:		City:	State:	ZIP Code:	
Social Security no.:		Home phone no.: ( )		Cell phone no.: ( )	
Birth date: / /	Age:	Sex: ❑ M ❑ F	Pharmacy Name:	Street your pharmacy is on:	
Occupation:		Employer:		Employer phone no.: ( )	
Do you have a living will? ❑Yes ❑No		Email Address:			
Do you have power of attorney? ❑Yes ❑No If yes, person's name:				Phone Number:	
Referred by (please check one box):		❑ Dr.	❑ Insurance Provider	❑ Hospital	
❑ Family	❑ Friend	❑ Website/Internet Search	❑ Yellow Pages	❑ Other	
Spouse's Name (if applicable):			Spouse's Date of Birth:		

INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Name of primary insurance:		Group no.:	Policy no.:	
Policy Holder's Name:	Birth date: / /	Policy Holder's S.S. no.:	Employer:	
Patient's relationship to policy holder:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance (if applicable):		Group no.:	Policy no.:	
Policy Holder's Name:	Birth date: / /	Policy Holder's S.S. no.:	Employer:	
Patient's relationship to policy holder:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY			
Name and address of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Patient Information

Patient's last name:	First:	Middle:	Date of Birth:

Today's Date: _____/_____/_____

REASON FOR VISIT TODAY (Please describe your problem/reason for visit in detail):

List Relevant Symptoms:

_____ _____

_____ _____

Are you allergic to any medications? (If so please list or circle below)

❑ *I have no known drug allergies* Latex Shellfish X-ray Dye Iodine

_____ _____

_____ _____

Are you on any medications? Please List:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you taking any blood thinners? ❑ Aspirin ❑ Plavix ❑ Coumadin (Warfarin) ❑ Fish Oil ❑ Vitamin E ❑ Pradaxa ❑ Xeralto

Do you smoke or use tobacco products?

❑ YES ❑ NO If yes, How many packs per day? _____

For how many years? _____

Do you drink alcoholic beverages?

❑ YES ❑ NO If yes, How many drinks per day? _____

Do you drink caffeine (soda, coffee, etc.)?

❑ YES ❑ NO If yes, How many drinks per day? _____

Patient Information

Patient's last name:	First:	Middle:	Date of Birth:

PATIENT PAST MEDICAL HISTORY: (Please list any medical conditions either current or past)

❑ Heart Disease	❑ Heart Attack	❑ Stroke
❑ Diabetes On Insulin? ❑ YES ❑ NO	❑ Cancer (Please specify type)	❑ Hypertension (High Blood Pressure)
❑ High Cholesterol	❑ Prostate Cancer	❑ Depression
❑ Kidney Stones	❑ Kidney Disease	❑ Dialysis
❑ HIV/AIDS	❑ Parkinson's	❑ Alzheimer's
❑ Hepatitis A / B / C	❑ Liver Disease	❑ Epilepsy or Seizures
❑ Other:		

PATIENT SURGICAL HISTORY: (Please list any surgeries you have had and the year they were performed)

Name of Surgery	Date of Surgery (Year)

FAMILY MEDICAL HISTORY: (Please list any medical conditions in your family and specify which family member)

CONDITION	FAMILY MEMBER (mother, father etc)	CONDITION	FAMILY MEMBER (mother, father etc)
❑ Heart Disease		❑ Prostate Cancer	
❑ Diabetes		❑ Cancer Type-	
❑ Stroke		❑ High Cholesterol	
❑ Alzheimer's		❑ Parkinson's	
❑ Heart Attack		❑ Kidney Disease	
❑ High Blood Pressure		❑ Dementia	
❑ Other:			

Patient Information

Patient's last name:	First:	Middle:	Date of Birth:

Review of Systems

Have you had any of the following problems recently?

GENERAL:		
❑ Weight loss or gain	❑ Fatigue	❑ Sleep Apnea
❑ Fever or chills	❑ Headaches	❑ Other: _____
EYES:		
❑ Blurry or double vision	❑ Glaucoma	❑ Cataracts
NEUROLOGICAL:		
❑ Dizziness	❑ Numbness/Tingling	❑ Seizures
❑ Fainting	❑ Tremors	❑ Paralysis/ Weakness
ENDOCRINE:		
❑ Excessive Thirst	❑ Tired/Sluggish	❑ Too Hot/Cold
GASTROINTESTINAL:		
❑ Abdominal Pain	❑ Nausea/Vomiting	❑ Stomach Ulcer
CARDIOVASCULAR:		
❑ Heart Trouble	❑ Chest pain or discomfort	❑ Heart Murmur
❑ High Blood Pressure	❑ Shortness of Breath	❑ Irregular Heart Beat
SKIN:		
❑ Rash	❑ Skin Lumps	❑ Psoriasis
MUSCULOSKELETAL:		
❑ Muscle or joint pain	❑ Back Pain	❑ Arthritis
EAR/NOSE/THROAT/MOUTH:		
❑ Sinus Problems	❑ Vertigo	❑ Hearing loss
RESPIRATORY:		
❑ Shortness of Breath	❑ Frequent Cough	❑ Tuberculosis
❑ Asthma	❑ Coughing up blood	❑ Wheezing
HEMATOLOGICAL/LYMPHATIC:		
❑ Swollen Glands	❑ Blood Clotting Problems	❑ HIV
PSYCHOLOGIC:		
❑ Depression	❑ Anxiety	❑ Suicidal Thoughts

FEMALE PREGNANCY HISTORY:

Number of Vaginal Deliveries _____ Number of Caesarians _____

AUA SYMPTOM SCORE (AUASS)

PATIENT NAME: _____ **TODAY'S DATE:** _____

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	LessThan Half the Time	About Half the Time	More Than Half the Time	Almost Always
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
During 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
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During 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
Over the past month, how many times per night 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

Add the score for each number above and write the total in the space to the right. **TOTAL:** _____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

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

The IIEF-5 Questionnaire (SHIM)

Please encircle the response that best describes you for the following five questions:

Over the past 6 months:					
1. How do you rate your confidence that you could get and keep an erection?	Very low 1	Low 2	Moderate 3	High 4	Very high 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost never of never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5

Total Score: _____

1-7: Severe ED 8-11: Moderate ED 12-16: Mild-moderate ED 17-21: Mild ED 22-25: No ED