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 _____

IT'S TIME TO TALK ABOUT OAB

Think You Have Overactive Bladder?

Do you think you have Overactive Bladder? Millions of men and women live with Overactive Bladder. This quiz will help you measure which Overactive Bladder (OAB) symptoms you have and how severe those symptoms are. Base your answers on the past month.

(Circle the response that best answers each question)

Symptom Questions	Not at all	Occasionally	About once a day	About three times a day	About half the time	Almost always	SCORE
1. Urgency – How often do you have a strong, sudden urge to urinate that makes you fear you will leak urine if you can't get to a bathroom immediately?	**0***	**1**	**2**	**3**	**4**	**5**	
2. Urgency Incontinence – How often do you leak urine after feeling an urge to go? (whether you wear pads/ protection or not)	**0**	**1**	**2**	**3**	**4**	**5**	
	None	**Drops**	**1 Tea-spoon**	**1 Table-spoon**	**¼ cup**	**Entire bladder**	
3. Incontinence – How much urine do you think usually leaks? (whether you wear pads/ protection or not)	**0**	**1**	**2**	**3**	**4**	**5**	
	1-6 times	**7-8 times**	**9-10 times**	**11-12 times**	**13-14 times**	**15 or more times**	
4. Frequency – How often do you urinate during the day?	**0**	**1**	**2**	**3**	**4**	**5**	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 times or more**	
5. Wake to urinate – How many times do you usually get up each night to urinate, from when you went to bed until you got up in the morning?	**0**	**1**	**2**	**3**	**4**	**5**	

TOTAL SYMPTOM SCORE (Add score from questions 1+2+3+4+5) =

0 = no symptoms

25 = most severe symptoms

*If you score 0 on question 1, you probably don't have OAB.

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IT'S TIME TO TALK ABOUT OAB

(Circle the response that best answers each question)

Quality of Life Questions How much does this bother you:	I am not bothered at all					I am bothered a great deal
1b. Urgency – a strong, sudden urge to urinate that makes you fear you will leak urine if you can't get to a bathroom immediately?	0	1	2	3	4	5
2b. Urgency Incontinence – leaking after feeling an urge to go?	0	1	2	3	4	5
3b. Frequency – urinating frequently	0	1	2	3	4	5
4b. Waking from sleep to urinate?	0	1	2	3	4	5
	I would not be bothered at all					I would be bothered a great deal
5b. Overall satisfaction – If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5

6b. How have your symptoms changed your life? – Please let us know how your symptoms (urgency, frequency, urine leakage, and waking at night) have changed your life. Are your symptoms:

(Please check all that apply)

- ❒ Keeping you from getting a good night's sleep?
- ❒ Causing you to stay home more than you would like?
- ❒ Keeping you from social activities or entertainment (movies, concerts, etc.)?
- ❒ Causing you to exercise (walking, sports, etc.) less or limit your physical activity?
- ❒ Causing problems with friends or loved ones
- ❒ Keeping you from traveling, taking trips, or using public transit?
- ❒ Making you plan trips around your knowledge of public restrooms?
- ❒ Causing problems at work?
- ❒ Other ways your symptoms have changed your life:

_____

_____

Score the "bother" questions (1b, 2b, 3b, 4b, 5b & 6b) separately. Do not add them together.

Even if you have mild symptoms, if they bother you enough to change your life, you and your healthcare professional should discuss what treatment options are available to you.

IT'S TIME TO TALK ABOUT OAB

Instructions – How do I use this Quiz?

Read this list of questions and answer them. Then bring your completed quiz to your next visit with your healthcare professional. This can be an easy way to start talking about your symptoms. The questions will help measure which Overactive Bladder (OAB) symptoms you have and how much your symptoms bother you. The better your healthcare professional knows the level and impact of your symptoms, the better he or she can help you manage them.

Scoring – What do my results mean?

For "Symptom Questions" (1 through 5):

Add 1 + 2 + 3 + 4 + 5 to get a score from 0 (no symptoms) to 25 (most severe symptoms).

What your total "Symptom" score means:

The higher your score for questions 1-5 are, the more severe your OAB symptoms are. However, if your score for question 1 is 0, then you do not have the hallmark symptom of Overactive Bladder – strong sudden urges to urinate that you cannot ignore. The answers to the "Symptom" questions can help you and your healthcare professional understand which of your OAB symptoms are most severe.

For "Quality of Life" Questions (1b, 2b, 3b, 4b, 5b, & 6b):

DO NOT add your "Quality of Life" scores together. Each "Quality of Life" question is scored separately.

What your "Quality of Life" results mean:

Questions 1b, 2b, 3b, 4b, 5b, & 6b on this quiz help show how your symptoms impact your life. We hope this will help you start a discussion with your healthcare professional about your symptoms. Seeing how much your symptoms have changed your life can help your healthcare professional decide what treatment choices to offer. Even if you have mild symptoms, if they bother you enough to change your life, you and your healthcare professional should discuss what treatment options are available to you.

What if I have other symptoms?

Please let your healthcare professional know about any other symptoms you may have. (For example, do you have urine leakage when sneezing or exercising? Do you have bladder pain? Do you have to strain to begin urinating?) This will help your healthcare professional figure out if your symptoms could be caused by something other than OAB. It will also help them offer the treatment choices that are best for you.

Where can I find a healthcare professional?

If you need a healthcare professional, visit **www.UrologyHealth.org/FindAUrologist** to find a urologist near you. Chose "incontinence" as a "special interest area" to find urologists who said they are interested in helping patients who leak urine or have OAB.

ItsTimeToTalkAboutOAB.org

For more information, contact:

Urology Care Foundation™
1000 Corporate Blvd., Linthicum, Maryland 21090
1-800-828-7866, **UrologyHealth.org**

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