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*****All information is strictly confidential, only your doctor, nurse and yourself will have access to this information!!**

REGISTRATION DATA (Female patients)

Full Name: Last _____ First _____ MI _____

Address: _____

Home phone: _____ Home FAX: _____

e-mail address: _____ Date of Birth: _____

Age: _____ Social Security Number: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Employer: _____

Employer phone number: _____ Employer FAX: _____

Insurance company: _____

Insurance company phone number: _____

Insurance identification number: _____

Name of your primary care doctor (referring doctor): _____

Address of your referring doctor: _____

Phone number for your referring doctor: _____

FAX number for your referring doctor: _____

Name of your preferred Pharmacy location: _____

Address of your Pharmacy: _____

Phone number of your pharmacy: _____

Fax number of your pharmacy: _____

Name of the lab you use: _____

Address of the lab: _____

Phone number of the lab: _____ Fax Number of the lab: _____

Name of immediate family members, relationship, contact numbers:

1.) _____

2.) _____

3.) _____

4.) _____

Who do you want us to contact in case of an emergency regarding your visit?

Emergency Contact: _____ Relationship: _____

Alternate Phone numbers: _____

I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorized the physician to release any information necessary to process an insurance claim.

A parent of guardian who will be responsible for payment must accompany the child at the time of the service. We cannot be bound by any divorce or other family relationship contracts.

Signature: _____ Date: _____

HISTORY DATA

CHIEF COMPLAINT: (In your own words, why are you here to see the urologist?)

Symptoms:(Regarding your chief complaint above?)

When:

Where:

How: (sharp, dull, stinging, pressure?)

Does anything make it better?

Does anything make it worse?

If you have pain, does it radiate from one area to another?

Have you had any past treatment from your
primary care doctor that referred you? Yes _____ No _____

Did your primary care doctor order any studies
before this appointment for this problem? Yes _____ No _____

Do you have any other general systemic symptoms such as:

Fever and/or chills? Yes _____ No _____

Nausea or vomiting? Yes _____ No _____

Diarrhea? Yes _____ No _____

Constipation? Yes _____ No _____

Headache? Yes _____ No _____

Weight loss? Yes _____ No _____

Night sweats? Yes _____ No _____

New onset bone pain? Yes _____ No _____

Recent chest pain? Yes _____ No _____

Recent episode of shortness of breath? Yes _____ No _____

Urology Specific Review:

Do you have any problems urinating? Yes _____ No _____

Obstructive symptoms:

Is your stream normal? Yes _____ No _____

Is your stream slow? Yes _____ No _____

Is your stream a dribble of urine? Yes _____ No _____

Do you spray when you urinate? Yes _____ No _____

Is your stream split? Yes _____ No _____

Does it take time to start your flow? Yes _____ No _____

Do you have intermittent flow? Yes _____ No _____

Do you void again within _ hour of the 1st? Yes _____ No _____

Do you strain to void? Yes _____ No _____

Do you feel incompletely emptied after void? Yes _____ No _____

Do you have dribbling after your done? Yes _____ No _____

Does your stream just abruptly stop in the middle? Yes _____ No _____

Have you ever not been able to urinate, where a catheter had to be placed? Yes _____ No _____

Irritative symptoms:

Do you have frequent urination? Yes _____ No _____

If yes, how often? _____ hours

Do you get up at night to urinate? Yes _____ No _____

Do you have urgent urination? Yes _____ No _____

Does it burn when you urinate? Yes _____ No _____

Do you leak urine? Yes _____ No _____

Does it happen when you cough or strain? Yes _____ No _____

Does it happen with exercise? Yes _____ No _____

Does it happen with running water? Yes _____ No _____

Does it happen at your front door? Yes _____ No _____

Do you have a pain in your lower abdomen at the time? Yes _____ No _____

Do you just not make it to the bathroom fast enough? Yes _____ No _____

Have you seen blood (red or tea colored) in your urine? Yes _____ No _____

If yes, is it?

Painless? Yes _____ No _____

At the beginning of urination? Yes _____ No _____

In the middle of urination? Yes _____ No _____

At then end of urination? Yes _____ No _____

Is it throughout the stream? Yes _____ No _____

Have you ever had problems with urinary tract infection? Yes _____ No _____

Have you ever had kidney stones? Yes _____ No _____

If yes,

How many times? _____

What type of treatment? _____

PAST MEDICAL HISTORY:

Do you have any of these medical illnesses?

- Cancer? Yes _____ No _____
If yes, what type? _____
- Heart disease? Yes _____ No _____
- Peripheral vascular disease? Yes _____ No _____
- Diabetes (Sugar)? Yes _____ No _____
- Neurological disorders or injuries? Yes _____ No _____
- Stroke? Yes _____ No _____
- Chronic infections of bladder,
kidney, prostate, testicles? Yes _____ No _____
- High Blood Pressure? Yes _____ No _____
- Gastrointestinal diseases? Yes _____ No _____
If yes, what are they? _____
- Any breathing problems? Yes _____ No _____
- Tuberculosis (TB)? Yes _____ No _____
- Kidney stones? Yes _____ No _____
- Glaucoma? Yes _____ No _____
- Chest Pain (angina)? Yes _____ No _____
- Asthma? Yes _____ No _____
- Inflammatory bowel disease? Yes _____ No _____
- Mitral Valve prolapse? Yes _____ No _____
- Pacemaker placement? Yes _____ No _____
- Peptic ulcer disease? Yes _____ No _____
- Blood clots in the legs? Yes _____ No _____
- Blood clots in the lungs? Yes _____ No _____
- Sickle Cell Trait/Disease? Yes _____ No _____
- Significant weight loss? Yes _____ No _____
- Use aspirin? Yes _____ No _____
- Use Blood thinners esp. Coumadin? Yes _____ No _____

Have you ever been hospitalized? Yes _____ No _____
If yes, when and for what? _____

Have you recently been to the Emergency Room? Yes _____ No _____
If yes, when and for what? _____

Are there any medical problems that you have
that are not listed above? Yes _____ No _____

If yes, please list them here:

PAST SURGERY HISTORY:

Any Childhood surgery? Yes _____ No _____
Hydrocelectomy Yes _____ No _____
Undescended testis (Orchidopexy) Yes _____ No _____
Hernia Yes _____ No _____
Others: (please list with procedure and year of surgery)

Any past surgery on the urinary system? Yes _____ No _____
(ex: kidney, bladder, prostate, stones, etc.) (Please list with procedure and year of surgery)

Any surgery of the female organs? Yes _____ No _____
(ex: hysterectomy, bladder suspensions, prolapse, etc.)(Please list with procedure and year of surgery)

Any general surgical abdominal surgery? Yes _____ No _____
(ex: bowel surgery, etc.)(Please list with procedure and year of surgery)

Any other surgeries, anywhere on the body not listed above?
(Please list with procedure and year of surgery)

MEDICATIONS (CURRENT):

Please list any prescription drugs, over the counter drugs (such as aspirin, Tylenol, cold medicines, etc.), Vitamins, herbal preparations, recreational drugs (marijuana, cocaine, anabolic steroids, etc.).

Do you take medications for infectious prophylaxis for cardiac conditions, foreign body implants or before dental procedures? Yes _____ No _____ if yes, what do you take?

ALLERGIES:

Have you ever had a reaction to a radiology dye or contrast agent? Yes _____ No _____
Do you have an allergy to shellfish or iodine products? Yes _____ No _____
Do you have allergies to these common medications; aspirin, penicillin antibiotics or sulfa-based antibiotics. Yes _____ No _____

Do you or your child have a LATEX allergy? Yes _____ No _____

Please list all drug allergies you have, please describe the reaction to the medication also.
(Itching, rash, hives, difficulty breathing, lowered blood pressure, hospitalization).

FAMILY HISTORY:

Do you or any member of your family have any of these conditions?

- MEN-I , II, or III? Yes _____ No _____
- Von Hippel Lindau disease? Yes _____ No _____
- Neurofibromatosis? Yes _____ No _____
- Tuberous sclerosis? Yes _____ No _____
- Renal cystic diseases? Yes _____ No _____
- Intersex disorders? Yes _____ No _____
- Cancers of any type? Yes _____ No _____
- Cystinuria? Yes _____ No _____
- Oxalosis? Yes _____ No _____
- Gout? Yes _____ No _____
- Tuberculosis? Yes _____ No _____
- High Blood Pressure? Yes _____ No _____
- Glaucoma? Yes _____ No _____
- Heart Trouble? Yes _____ No _____

Please list any genetic, hereditary or familial diseases that run in your family?

GYN and MENSTRUAL HISTORY:

(For Females only)

- How many pregnancies have you had? _____
- How many miscarriages have you had? _____
- Have you had any abortions have you had? _____
- How many live births have you had? _____

- Give the date of your last menstrual period? _____
- Menstrual Periods began at age? _____
- Menstrual Periods ended at age? _____

COULD YOU BE PREGNANT NOW? Yes _____ No _____

Do you have regular periods? Yes _____ No _____
If yes how many days between? _____

SOCIAL HISTORY:

Do you drink more than 4 cans of beer in one day? Yes _____ No _____
If yes, how many? _____

Do you drink more than 2 mixed drinks or shots per day? Yes _____ No _____
 If yes, how many? _____
 Do you take any recreational drugs or street drugs? Yes _____ No _____
 If yes, what? _____
 Do you smoke cigarettes? Yes _____ No _____
 If yes, how many pack/day and years? _____
 If no, have you ever smoked in the past? Yes _____ No _____
 If yes, how many packs/day and years? _____
 Do you smoke cigars or pipe? Yes _____ No _____
 Do you chew tobacco? Yes _____ No _____
 Coffee, tea or soda? Yes _____ No _____

What do you do for an occupation? _____
 Is there any possibility of chemical or toxic exposure? _____

REVIEW OF SYSTEMS:

General: (included in chief complaint section)

Head, ears, nose and throat problems? Yes _____ No _____
 Any lumps in your neck? Yes _____ No _____
 Frequent infections? Yes _____ No _____
 Any eyesight problems? Yes _____ No _____
 Glaucoma? Yes _____ No _____
 Any hearing problem? Yes _____ No _____
 Any dizziness? Yes _____ No _____
 Sinus problems? Yes _____ No _____
 Nose Bleeds? Yes _____ No _____
 Ringing in the ears? Yes _____ No _____
 Deafness? Yes _____ No _____
 Post Nasal Drip? Yes _____ No _____
 Broken ear drum? Yes _____ No _____

Any problems with your lungs or breathing? Yes _____ No _____
 Shortness of breath? Yes _____ No _____
 Asthma? Yes _____ No _____
 Wheezing? Yes _____ No _____
 Gurgling sounds? Yes _____ No _____
 Ever cough up blood? Yes _____ No _____
 Ever have pneumonia? Yes _____ No _____
 Any others? Yes _____ No _____
 Explain:
 Persistent cough? Yes _____ No _____
 Emphysema? Yes _____ No _____
 Pain with breathing? Yes _____ No _____

Any problems with your heart? Yes _____ No _____
 Any heart attacks? Yes _____ No _____
 How many and when? _____
 Any chest pain/angina? Yes _____ No _____

Chest Pain with exertion? Yes _____ No _____
Indigestion? Yes _____ No _____
Heartburn? Yes _____ No _____
Radiation of pain to
neck or arms? Yes _____ No _____
Murmurs? Yes _____ No _____
Enlarged Heart? Yes _____ No _____
Irregular Heart Beat? Yes _____ No _____
Fluttering in the chest? Yes _____ No _____
Ankle swelling? Yes _____ No _____
High Blood Pressure? Yes _____ No _____

Any problems with your gastrointestinal system? Yes _____ No _____

Nausea, vomiting? Yes _____ No _____
Diarrhea, constipation? Yes _____ No _____
Rectal bleeding? Yes _____ No _____
Vomit coffee grounds? Yes _____ No _____
Blood in toilet after BM? Yes _____ No _____
Ulcers? Yes _____ No _____
Gastritis? Yes _____ No _____
Heartburn? Yes _____ No _____
Acid reflux? Yes _____ No _____
Difficulty swallowing? Yes _____ No _____
Indigestion? Yes _____ No _____
Liver Disease? Yes _____ No _____
Cirrhosis? Yes _____ No _____
Hepatitis? Yes _____ No _____
Gallbladder trouble? Yes _____ No _____
Vomit Red Blood? Yes _____ No _____
Black bowel Movements? Yes _____ No _____
Hemorrhoids? Yes _____ No _____
Yellow Jaundice? Yes _____ No _____

Any problems with your Kidneys? Yes _____ No _____

Kidneys stones? Yes _____ No _____
Kidney infections? Yes _____ No _____

Any problems with your nervous system? Yes _____ No _____

Bad Headaches? Yes _____ No _____
Seizures? Yes _____ No _____
Epilepsy? Yes _____ No _____
Head injury? Yes _____ No _____
Fainting? Yes _____ No _____
Loss of Consciousness? Yes _____ No _____
Paralysis? Yes _____ No _____
Numbness? Yes _____ No _____
Double vision? Yes _____ No _____
Blurred vision? Yes _____ No _____
Staggering? Yes _____ No _____

Any problems with your female organs? Yes _____ No _____
Any problems with your muscles or joints? Yes _____ No _____
Any vascular problems? Yes _____ No _____
Pain in extremities with activity? Yes _____ No _____
Varicose veins? Yes _____ No _____
Have you ever had a blood disorder or bleeding problem? Yes _____ No _____
Do you take aspirin? Yes _____ No _____

IF THERE IS ANYTHING ELSE IN YOUR MEDICAL HISTORY THAT YOU THINK YOUR DOCTOR SHOULD BE AWARE OF NOT INCLUDED ABOVE PLEASE LIST IT HERE:

I read the above questionnaire and this information is true to the best of my knowledge.

Patient Signature: _____ Date: _____