John J. Bauer, M.D.
www.flinturology.com

Urology Services, Inc.
G-1121 West Hill Rd.
Flint, Michigan 48507
Tel: 810.232.8888
Fax: 810.232.9190
Email: jbauer@flinturology.com

*****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 you 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_____

Irrative 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_____
Hydroceolectomy 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: _____