Griffith Urology, PLLC
575 S. Wickham RD. Suite A
West Melbourne, FL 32904
P: 321-727-8940 F: 321-733-7050

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (MI) (Nickname)

DOB: ___/___/_____ Male [ ] Female [ ] Other [ ]

Address: _____
(Street) (City and State) (Zip Code)

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Email Address:_____ Marital Status: _____

Spouse or Parent: _____ Emergency Contact: _____

Address: _____ Relationship: _____)_____

_____ Number: _____

Primary Physician: _____ Pharmacy/location: _____

Please circle one for each category:

Ethnicity: Hispanic Non-Hispanic Do Not Wish To Disclose

Race: Black or African American White Native American or Alaska Native Asian
Native Hawaiian or other Pacific Islander Other Do Not Wish To Disclose

Preferred Language: English Spanish French Indian (include Hindu & Tamil) other _____

INSURANCE INFORMATION

No need to fill out if you brought your insurance cards

Primary Insurance Co.: _____ Policy #: _____

Name of Insured: _____ DOB: _____ Group # _____

Secondary Insurance Co.: _____ Policy #: _____

Name of Insured: _____ DOB: _____ Group # _____

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Treatment
By signing below, I authorize treatment by Griffith Urology, PLLC physicians and their staff.

HIPPA
By signing below, I acknowledge, I have been offered/received a copy of the Notice of Health Information Practices.

Financial and Insurance Policy Understanding: I understand that I am financially responsible for all charges for all service to me, including co-payments, co-insurance, out-of-pocket, deductibles, and non-covered services. I authorize the payments from my insurance company (ies) according to my medical benefits be made payable to Griffith Urology, PLLC for professional services rendered. I understand that I will receive statements, reflecting my account balance and the **final** payment of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fees. I authorize the disclosure of my medical information to Griffith Urology, PLLC as well as to my insurance company (ies).

Appointment Policy: Griffith Urology, PLLC reserves the right to halt provider care if the following should occur: being a "no-show" of multiple appointments or procedures and/or any surgery (ies).

Patient with Medicare Coverage
I certify that the information given by me in applying for payment under Title XVII od the Social Security ACT is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician and authorize such physician to submit a claim to Medicare.

Non-Medicare Patient
I authorize the release of all medical information to my insurance company (ies) and request that payment of my insurance benefits be sent directly to Griffith Urology, PLLC (unless payment in full has been made at time of service).

Contact
By signing below, I authorize all the contacts to be used to communicate with me regarding my treatment, billing, or services rendered, including a detailed message on my answering machine.

Lifetime Signature Authorization: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information is current.

Signed: _____ Date: _____

Patient Printed Name: _____

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I authorize Griffith Urology, PLLC to discuss my healthcare information with:

Name	Relationship	Phone Number

Name	Relationship	Phone Number

Signature	Printed Name	Date

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Patient History Forms

Name: _____ Date of Birth: _____

History of Present Illness

Chief Complaint (What is the main reason for your visit today?): _____

_____

Blood in urine? Y / N
Color of urine? Bright red ___, Dark Red _____
Pink ___, Yellow____, Microscopic blood ____
Clots in urine? Y / N
Frequent urination? Y / N
Nocturia (urinating at night)? Y / N
How often? _____ times a night

Slow or weak stream? Y / N
Burning with urination? Y / N
Leaking of urine? Y / N With urge? Y / N
With cough? Y / N With exercise? Y / N
Pain with intercourse? Y / N
Have you had this issue before? Y / N
When? _____

List all medications including over the counter medications, vitamins, and herbal supplements

(Name of medication, dose, times per day)_____

_____

_____

_____

_____

_____

_____

_____

_____

Past Medical History

Circle all that apply and fill in all other medical history: Urinary tract Infection, kidney stones, prostate problems, cancer/type _____, heart attack, heart murmur, heart disease, high blood pressure, vascular disease, stroke, blood clots, diabetes, epilepsy/seizures, asthma, COPD, Emphysema, pneumonia, acid reflux, IBS, other _____

_____

_____

_____

_____

Allergies and reaction _____

Surgical history: type of surgery and date: _____

_____

_____

Hospitalizations: reason and type: _____

_____

Family and Social History

Does anyone in your family have a history of: diabetes, hypertension, heart disease, high cholesterol, cancer or mental illness? Please fill in who

Mother _____ Father _____ Sister _____ Brother _____

Son _____ Daughter _____ Grandparent _____

Tobacco use what/how much : _____ Alcohol use how much: _____

Caffeine intake (soda, tea, coffee) what/ how much: _____

Vital Signs

BP _____ HR _____ RR _____ Temp. _____ O2 sat _____

Wt. _____ HT _____ BMI _____ Pain where/scale _____

International Prostate Symptom Score (IPSS)

Patient Name: **Date of Birth:** **Age:** **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 you have 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	Once 1	Twice 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 Dissatis-	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

Would you be interested in treatment options?	Yes	No

ADAM Questionnaire

The androgen deficiency in aging males (ADAM) questionnaire has been shown to be highly effective for screening patients with potential testosterone deficiency.

Please circle your answers:

1.	Do you have a decrease in libido (sex drive)?	Yes	No
2.	Do you have a lack of energy?	Yes	No
3.	Do you have a decrease in strength, endurance, or both?	Yes	No
4.	Have you lost height?	Yes	No
5.	Have you noticed a decreased enjoyment of life?	Yes	No
6.	Are you sad, grumpy, or both?	Yes	No
7.	Are your erections less strong?	Yes	No
8.	Have you noticed a recent deterioration in ability to play sports?	Yes	No
9.	Are you falling asleep after dinner?	Yes	No
10.	Has there been a recent deterioration in your work performance?	Yes	No

A “Yes” to questions 1-7, or any 3 questions in total, suggests the presence of testosterone deficiency. The diagnosis can be confirmed with a standard blood test.

Overactive Bladder Validated 8 Question Screener

The questions below ask about how bothered you may be by some bladder symptoms. Some people are bothered by bladder symptoms and may not realize that there are treatments available for their symptoms.

Please circle the number that describes how much you have been bothered by each symptom. Add the numbers together for a total score and record the score in the box provided at the bottom.

How bothered have you been by…	Not at all	A little bit	Somewhat	Quite a bit	A great deal	A very great deal
Frequent urination during the daytime hours?	0	1	2	3	4	5
An uncomfortable urge to urinate?	0	1	2	3	4	5
A sudden urge to urinate with little to no warning?	0	1	2	3	4	5
Accidental loss of small amounts of urine?	0	1	2	3	4	5
Nighttime urination?	0	1	2	3	4	5
Waking up at night because you have to urinate?	0	1	2	3	4	5
An uncomfortable urge to urinate?	0	1	2	3	4	5
Urine loss associated with a strong desire to urinate?	0	1	2	3	4	5

Are you male? If you are a male add 2 points to your score

Please add up your responses to the questions above _____

If your score is 8 or greater, you may have overactive bladder. There are effective treatments for this condition. You may want to talk with your healthcare professional about your symptoms.

Note: You may be asked to give a urine sample. Please ask before going to the bathroom.

Interstitial Cystitis and Problem Questionnaire

To help your clinician determine if you have interstitial cystitis (IC), please put a check mark next to the most appropriate response to each of the questions shown below. Then add up the numbers next to the checkmarks in the 2 sections individually below.

IC Symptom Index

During the past month:

1. How often have you felt the strong need to urinate with little to no warning?
   - 0. ___ not at all
   - 1. ___ less than 1 in 5 times
   - 2. ___ less than half the time
   - 3. ___ about half the time
   - 4. ___ more than half the time
   - 5. ___ almost always

2. Have you had to urinate less than 2 hours after you finished urinating?
   - 0. ___ not at all
   - 1. ___ less than 1 in 5 times
   - 2. ___ less than half the time
   - 3. ___ about half the time
   - 4. ___ more than half the time
   - 5. ___ almost always

3. How often did you most typically get up at at night to urinate?
   - 0. ___ none
   - 1. ___ once
   - 2. ___ twice
   - 3. ___ 3 times
   - 4. ___ 4 times
   - 5. ___ 5 or more times

4. Have you experienced pain or burning in your bladder?
   - 0. ___ not at all
   - 1. ___ once or twice
   - 2. ___ a few times
   - 3. ___ fairly often
   - 4. ___ usually
   - 5. ___ almost always

Total Score: _____

IC Problem Index

During the past month, much has the following been a problem for you:

1. Frequent urination during the day?
   - 0. ___ no problem
   - 1. ___ very small problem
   - 2. ___ small problem
   - 3. ___ medium problem
   - 4. ___ big problem

2. Getting up at night to urinate?
   - 0. ___ no problem
   - 1. ___ very small problem
   - 2. ___ small problem
   - 3. ___ medium problem
   - 4. ___ big problem

3. Need to urinate with little warning?
   - 0. ___ no problem
   - 1. ___ very small problem
   - 2. ___ small problem
   - 3. ___ medium problem
   - 4. ___ big problem

4. Burning, pain, discomfort, or pressure In your bladder?
   - 0. ___ no problem
   - 1. ___ very small problem
   - 2. ___ small problem
   - 3. ___ medium problem
   - 4. ___ big problem

Total Score: _____