



Dear: \_\_\_\_\_

Thank you for choosing our office; we would like to make your visit with us as comfortable as possible.  
Your appointment is scheduled:

\_\_\_\_\_ at: \_\_\_\_\_ with \_\_\_\_\_

Day

Date

Time

Doctor

We will make every effort to notify you as soon as possible if a medical emergency demands we change your appointment. Please notify our office as far in advance as possible if you will be unable to keep your appointment so that we may give your appointment time to another patient.

At the time of your appointment, please bring the following information to make your first visit more productive:

1. **Your insurance cards and/or Medicare card and a Picture ID.** If your insurance requires a written referral from your primary care doctor, please bring it with you. If your insurance requires a numbered "telephone" referral, please verify with your primary physician that this has been called in and when available, bring that number with you. **You must present a picture ID to be seen.**
2. **Copies of your medical records to date**, including any recent x-rays or lab results. **If you are seeing our doctor to review x-rays or CT's that were previously taken you must bring the actual films or CD's with you.**
3. **A current list of medications** you are taking and their dosages. This is very important to assist us in prescribing additional medication. We will periodically ask you to update this information.
4. **This packet of information completed** and ready to give to our office personnel.
5. **Required Co-Pays for your insurance.** We do not bill co-pays. They are due at the time of service.

We have enclosed a copy of our Patient Privacy Summary Notice. A complete Privacy Notice is available for your review.

**New Patients must arrive 30 minutes prior to your doctor appointment so that we may complete the registration process. Late arrivals may have to be rescheduled.**

If you have any questions, please give us a call at 816-251-5100.

Wm. Tad Wilson, MD • Brad K. Stanley, MD • David C. Lewing, MD, John R. Moore, MD • James S. McIntosh, MD •  
Ryan T. Miller, MD Elizabeth A Piontek MD, Eric DeRoo MD, Derek Jensen, MD, Margaret Higgins, MD, Daniel  
Ensley, MD

## Advanced Urologic Associates – Intake Form

Today's Date: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Local Pharmacy and Location: \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

**Medications: Please include dosage and how many times a day. If you have an up to date copy we can copy it on the day of your appointment.**

1. \_\_\_\_\_ 8. \_\_\_\_\_

2. \_\_\_\_\_ 9. \_\_\_\_\_

3. \_\_\_\_\_ 10. \_\_\_\_\_

4. \_\_\_\_\_ 11. \_\_\_\_\_

5. \_\_\_\_\_ 12. \_\_\_\_\_

6. \_\_\_\_\_ 13. \_\_\_\_\_

7. \_\_\_\_\_ 14. \_\_\_\_\_

**Allergies:** \_\_\_\_\_ **Reaction:** \_\_\_\_\_

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**Personal Medical History: Please check all that apply.**

Arthritis \_\_\_\_ Elevated PSA \_\_\_\_ Hypertension \_\_\_\_ Prostate Cancer \_\_\_\_

Bladder Cancer \_\_\_\_ Prostatitis \_\_\_\_ Breast Cancer \_\_\_\_ Epididymitis \_\_\_\_

Enlarged Prostate \_\_\_\_ kidney disease \_\_\_\_ Kidney Stones \_\_\_\_ Renal Cancer \_\_\_\_

Heart Disease \_\_\_\_ Diabetes \_\_\_\_ STD \_\_\_\_ Interstitial Cystitis \_\_\_\_

Erectile Dysfunction \_\_\_\_ GERD \_\_\_\_ Hormone Problems \_\_\_\_ Testicular Cancer \_\_\_\_

UTI \_\_\_\_ Urinary Incont. \_\_\_\_ HIV \_\_\_\_ Taking blood thinners \_\_\_\_

**Surgical History: Please list dates if known.**

Appendectomy \_\_\_\_ Bladder Sling \_\_\_\_ Cholecystectomy \_\_\_\_ Colon Surgery \_\_\_\_  
Hernia Repair \_\_\_\_ Kidney Removal \_\_\_\_ Kidney Stone Surgery \_\_\_\_ Lithotripsy \_\_\_\_  
Prostate Surgery \_\_\_\_ Kidney Transplant \_\_\_\_ Tonsillectomy \_\_\_\_ Incontinence Surgery \_\_\_\_  
Orthopedic Surgery \_\_\_\_ Heart Valve Surgery \_\_\_\_ Heart Surgery \_\_\_\_

**Family History: Please Indicate whom below.**

**M** – Mother, **F** – Father, **B** – Brother, **S** – Sister, **MGM** – Maternal Grandmother, **MGF** – Maternal Grandfather,  
**PGM** – Paternal Grandmother, **PGF** – Paternal Grandfather

Kidney Stones \_\_\_\_\_ Diabetes \_\_\_\_\_ Thyroid Disease \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Prostate Cancer \_\_\_\_\_ Stroke \_\_\_\_\_  
Kidney Cancer \_\_\_\_\_ Lung Problems \_\_\_\_\_ Bladder Cancer \_\_\_\_\_  
Any other Conditions: \_\_\_\_\_

**Social History: Circle Y (Yes) or N (No) and answer questions completely.**

Drink Caffeine? # Servings per day \_\_\_\_\_ Coffee \_\_\_\_, Tea \_\_\_\_, Soda \_\_\_\_, Energy Drinks \_\_\_\_

Do You Smoke? Y or N Cigarettes \_\_\_\_, Cigars \_\_\_\_, Pipe \_\_\_\_. # per day \_\_\_\_\_, # of year's \_\_\_\_\_

Ever Smoked? Y or N Year Quit: \_\_\_\_\_

Do you Chew Tobacco? Y or N

Drink Alcohol? Y or N Amount? \_\_\_\_\_ Daily? Y or N Weekly? Y or N Occasionally? Y or N

Do you use Illicit drugs? Y or N Type: \_\_\_\_\_

## **AUA SYMPTOM SCORE**

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

| (Circle One Number on Each Line)                                                                                                                                        | Not at All | Less Than 1 Time in 5 | Less Than 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:                                                                                                                     | 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        |

**Have you tried medications to help your symptoms? (Circle one) YES / NO**

**Did these medications help your symptoms? (Circle number)**

|   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

*No Relief(1)*

*Complete Relief (10)*

**Male Patients Only:** Would you be interested in learning about a minimally invasive option that would allow you to discontinue your BPH (benign prostatic hypertrophy) medications? (Circle One) **YES / NO**

# Review of Systems

Please Circle any symptoms you have experienced in the last 30 days.

| Constitution:   | Eyes:                  | GI:                       | Endo/Heme/Aller      |
|-----------------|------------------------|---------------------------|----------------------|
| Fever           | Blurred Vision         | Heartburn                 | Easy Bruise/Bleed    |
| Chills          | Double Vision          | Nausea                    | Environ. Allergies   |
| Weight Loss     | Photophobia            | Vomiting                  | Polydipsia           |
| Malaise/Fatigue | Eye Pain               | Abdominal Pain            |                      |
| Diaphoresis     | Eye Discharge          | Diarrhea                  | <b>Neurological:</b> |
|                 | Eye Redness            | Constipation              | Dizziness            |
| <b>Skin:</b>    |                        | Blood in Stools           | Headache             |
|                 | <b>Cardiovascular:</b> | Melena                    | Tingling             |
| Rash            |                        |                           | Tremors              |
| Itching         | Chest Pain             | <b>Urinary:</b>           | Sensory Change       |
|                 | Palpitations           |                           | Speech Change        |
| <b>HEENT:</b>   | Orthopnea              | Urgency                   | Focal Weakness       |
| Hearing Loss    | Claudication           | Frequency                 | Weakness             |
| Tinnitus        | Leg Swelling           | Hematuria                 | Seizures             |
| Ear Pain        | PND                    | Flank Pain                | LOC                  |
| Ear discharge   | Elevated B/P           | Urinating at Night        |                      |
| Nosebleeds      |                        | Loss of Urine Control     | <b>Psychiatric:</b>  |
| Congestion      | <b>Respiratory:</b>    | Slow Stream               |                      |
| Sinus Pain      |                        | Urinary Tract Infections  | Depression           |
| Stridor         | Cough                  | Bladder Pain              | Suicidal Ideas       |
| Sore Throat     | Hemoptysis             | Kidney Stones             | Substance Abuse      |
|                 | Sputum Prod.           | Difficulty with Erections | Hallucinations       |
|                 | SOB                    | Vaginal Discharge         | Nervous/Anxious      |
|                 | Wheezing               | Estrogen Supplement       | Insomnia             |
|                 |                        | Hesitancy                 | Memory Loss          |
|                 |                        | <b>Musculoskeletal:</b>   |                      |
|                 |                        | Myalgia                   |                      |
|                 |                        | Neck Pain                 |                      |
|                 |                        | Back Pain                 |                      |
|                 |                        | Joint Pain                |                      |
|                 |                        | Falls                     |                      |