Stony Brook Medicine

Department of Urology New Patient Intake Form—Female

*Last Name*_____ *First Name*_____
Date of Birth: ____/____/____ *Social Security Number:*_____
*Referring Physician:*_____ *Phone #:* _____
Physician Address: _____

History of Present Illness

Please answer the following questions

Chief Complaint

What is the main reason for your visit today?

☐ Bladder Cancer
☐ Urinary Tract Infections
☐ Renal Cyst/ Mass
☐ Urinary Frequency
☐ Hematuria (Blood in Urine)
☐ Kidney Stones
☐ Urinary Incontinence
☐ Other: _____

Which symptoms best describe you? Check all that apply.

- ☐ Frequent Urination—day, night, or both
- ☐ Sudden or strong urge to urinate
- ☐ Leakage with little or no warning----sometimes unable to make it to the bathroom in time
- ☐ Unable to completely empty the bladder-----feels like there is more even after going to the bathroom
- ☐ Accidental leakage with physical activity---exercising, sneezing, or coughing
- ☐ Bladder or pelvic pain
- ☐ Problems with bowel function (if checked, please select symptom below)
  - ☐ Accidental loss or leakage of stool ☐ Constipation ☐ Other
- ☐ No Bladder or bowel problems

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No

If yes, how many different medications have you tried? _____

On a scale from 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number

0	1	2	3	4	5	6	7	8	9	10
No Relief										Complete Symptom Relief

Are you still taking any of these medications? ☐ Yes ☐No

If no, why have you stopped taking them?

☐ Did not work as well as expected ☐ Side effects ☐Expense
☐ Interaction with other medications ☐Other

If side effects or other checked, please explain: _____

Behavior modifications tried? _____

(I.e., reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

On a scale from 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number

0	1	2	3	4	5	6	7	8	9	10
Not Frustrated										*Extremely Frustrated*

Urogenital Distress Inventory Short Form (UDI-6)

Please answer each question by checking the best response. While answering these questions, please consider your symptom over the last 3 months. We realize that you may not be having problems in some of these areas, but please fill out this form as completely as possible.

Do you experience, and if so, how much are you bothered by …	Not at all	Slightly	Moderately	Greatly
Frequent Urination	0	1	2	3
Leakage related to feeling of urgency	0	1	2	3
Leakage related to physical activity, coughing, or sneezing	0	1	2	3
Small amounts of leakage (drops)	0	1	2	3
Difficulty emptying bladder	0	1	2	3
Pain or discomfort in lower abdominal or genital area	0	1	2	3

INCONTINENCE IMPACT QUESTIONAIRE-SHORT FORM (IIQ-7)

Some people find accidental urine loss may affect their activities, relationships, and feelings. The questions below refer to areas in your life that may have been influenced or changed by your problem. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage.

Has urine leakage affected your …	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
2. Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
3. Entertainment activities (movies, concerts, etc.)?	0	1	2	3
4. Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
5. Participation in social activities outside your home?	0	1	2	3
6. Emotional health (nervousness, depression, etc.)?	0	1	2	3
7. Feeling frustrated?	0	1	2	3

Items 1 and 2 = physical activity; Items 3 and 4 = travel
Items 5 = social/relationships; items 6 and 7 = emotional health

Scoring: Item responses are assigned values of 0 for “not at all,” 1 for “slightly,”2 for “moderately,” and 3 for “greatly.” The average score of items responded to is calculated. The average, which ranges 0 to 3, is multiplied by 33 1/3 to put scores on a scale of 0 to 100.

Reference: Uebersax, J.S., Wyman, J.F., Shumaker, S.A, McClish, D.K, Fantl, J.A., & the Continence Program for Women Research Group. (19950. Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory. *Neurology and Urodynamics*, 14(2), 131-139.

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Past Medical & Social History

Please answer the following questions

Medical History

Please check if **you** have ever had any of the following:

☐ Parkinson's ☐ Multiple Sclerosis
☐ Heart Disease ☐ Heart Attack
☐ High Blood Pressure ☐ Lung (COPD, Asthma)
☐ High Cholesterol/triglyceride ☐ Sexually transmitted disease
☐ Stroke/TIA ☐ Diabetes
☐ Thyroid ☐ Seizures/Epilepsy
☐ Cancer: Type_____
☐ Kidney/Bladder (Renal Cyst, Renal Mass, Stones)
☐ Anxiety, depression or mental illness
☐ Blood disorders (abnormal bleeding anemia, high or low white count)
☐ Other _____
_____

Are you pregnant? Y / N
How many Pregnancies? _____How many children? _____
Vaginal _____ C-section_____
Date of last menstrual period: _____

Surgical History

1. Have you ever had surgery? ☐ Yes ☐ No
2. Please list approximate dates and reasons for any surgery (including childbirth):

Date Surgeries

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medications

1. Please list any prescription medications you are currently taking and their dosages.

Medication Name	Dosage	Reason for taking

Medications cont.

2. Please indicate if you are taking of the following over the counter medications:

☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen
☐ Antacid ☐ Laxatives ☐ Decongestants
☐ Antihistamines ☐Vitamins/Mineral Supplements
☐ Other: _____ _____
_____ _____

Pharmacy

Pharmacy Name: _____
Pharmacy Address: _____
_____
Pharmacy Phone Number: _____

Allergies

Do you have any allergies? ☐ Yes ☐ No
If yes please specify below:

_____ _____ _____
_____ _____ _____

Social History

Occupation: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
Do you smoke? ☐ Yes ☐ No
How much? _____
Have you smoked in the past? ☐ Yes ☐ No
How Long? _____
Do you drink alcohol? ☐ Yes ☐ No How Much?
Beer_____
Wine _____
Liquor _____
Do you drink Caffeine? ☐ Yes ☐ No How Much?
Coffee _____
Tea _____
Soda_____
Are you on a special diet? ☐ Yes ☐ No
If yes please Specify: _____

Family History

Please list all serious illnesses in your immediate family;
(Example: Diabetes, Cancer, Tuberculosis, Heart disease)
Mother: Age_____ ☐ Living: _____
☐ Deceased- Cause: _____
Father: Age_____ ☐ Living: _____
☐ Deceased-Cause: _____
Sister: _____ _____
Brother: _____ _____

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Department of Urology New Patient Intake Form—Female

Review of symptoms

Are you currently having problems with the following? Circle yes (y) or no (N)

Constitutional Symptoms

Fever	Y|N
Chills	Y|N
Sweats	Y|N
Weakness	Y|N
Fatigue	Y|N

Eyes

Blurred Vision	Y|N
Double Vision	Y|N
Pain	Y|N

Immunologic

Recurrent Fevers	Y|N
Recurrent Infections	Y|N
Malaise	Y|N

Neurological

Confusion	Y|N
Numbness/Tingling	Y|N
Dizzy Spells	Y|N
Headache	Y|N

Endocrine

Excessive Thirst	Y|N
Too hot/Cold	Y|N
Excessive Hunger	Y|N

Gastrointestinal

Abdominal Pain	Y|N
Nausea/Vomiting	Y|N
Indigestion/heartburn	Y|N
Diarrhea	Y|N

Cardiovascular

Chest Pain	Y|N
Palpitations	Y|N
Ankle Swelling	Y|N

Physician Signature: _____

Date: _____

Integumentary

Skin Rash	Y|N
Boils	Y|N
Persistent itch	Y|N
Burns	Y|N
Skin Lesion	Y|N

Musculoskeletal

Joint pain	Y|N
Neck Pain	Y|N
Back Pain	Y|N

Ears/Nose/Throat/Mouth

Ear Infection	Y|N
Sore Throat	Y|N
Sinus Problems	Y|N

Genitourinary

Urine Retention	Y|N
Painful Urination	Y|N
Urinary Frequency	Y|N
Blood in Urine	Y|N

Respiratory

Wheezing	Y|N
Frequent Cough	Y|N
Shortness of breath	Y|N

Hematologic/Lymphatic

Swollen glands	Y|N
Blood clotting problems	Y|N
Bruising tendency	Y|N

Psychologic

Depression	Y|N
Anxiety	Y|N

Ambulatory Care
Consent and Notice of Privacy Practices
Acknowledgement Form

Patient Name: _____ Date of Birth: _____

MRN: _____ Enc#: _____

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff. I have been provided a copy of the SBOHCA Joint Notice of Privacy Practices (Notice) and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.

I acknowledge the receipt of the Ambulatory Care Patient Guide on, or prior to this visit.

_____
Signature of Patient or Patient Representative

_____
Print Name of Patient or Personal Representative

_____
Relationship, if signed by person other than Patient

_____ _____
Date Time

_____
Signature of Witness

_____
Print Name of Witness

_____ _____
Date Time

SPANISH VER.:AD2C037ST

AD2C034 (2/13)

Stony Brook Medicine

Ambulatory Care
Authorization to Discuss PHI with a Designee

Patient's Name: _____ Date of Birth: _____
(Please Print Clearly) (Please Print Clearly)

By signing below I hereby give permission to _____
(Name of Physician, Physician Practice or Service Practice)

to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this **does not** include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

_____
Signature of Patient

_____ _____
Date Time

For Office Use Only

Patient's MRN _____

Date received: _____

This form is for office use only. Place in the correspondence section of the medical record. Not for release or disclosure.