

How did you find out about Dr. Watson?

M

- Another Person ... Who? _____
- Another Doctor ... Who? _____
- Other ... How? _____

- Yellow Pages _____
- Newspaper _____
- Internet _____

Full Name: _____ DATE: ____/____/____

Telephone Numbers: (home) (____) ____-____-____ (work) (____) ____-____-____
 (cell phone) (____) ____-____-____ (other phone) (____) ____-____-____

Address: _____ City: _____ Zip Code: _____

E-mail: _____

Social Security Number: ____/____/____ (This is used as a unique medical record number.)

Date of Birth: ____/____/____

Your Primary Care or Family Doctor: _____

Other Doctors you use: _____

Name of spouse: _____

Person Responsible for Payment: _____
 Telephone Number or Person Responsible for Payment: (____) ____-____-____
 Address (of above person): (street/box) _____ (city & state) _____ (zip) _____
 Employer (of above person): _____

Primary (first) Insurance Company: _____
 Policy Number: _____ Group Number: _____

Secondary (second) Insurance Company: _____
 Policy Number: _____ Group Number: _____

I hereby grant my permission to copy and transfer my medical records in order to determine eligibility for insurance coverage and to promote continuity of excellent health care for myself or the aforementioned person whom I represent. I understand that my permission may be revoked at any time upon my written and signed request.

~~X~~ _____ DATE: ____/____/____

I understand that there are certain health care products and services which my physicians may determine to be standard care, desirable or necessary that Medicare, Medicaid or other third party insurers will not reimburse or approve.

~~X~~ _____ DATE: ____/____/____

I understand that I have a right to decline any or all forms of testing, medication, treatment and surgery before the these treatments are rendered and that I may question my insurer as to the payment benefits which I may expect for myself or the aforementioned person whom I represent. However, I understand that I am personally responsible for immediate payment of reasonable and customary charges for any service not otherwise paid by my insurer. I understand that this payment is due on the date the medical service is rendered.

~~X~~ _____ DATE: ____/____/____



CC/HPI

How old are you presently? _____

Why are you here to see Dr. Watson today? Please do **NOT** write "checkup" or "appointment" or "doctor sent me". Be as **specific** as possible about why you are here. Dr. Watson can help only if he knows upfront, about the **exact** reason that you need care. _____

Please complete this sentence: I am worried about _____

Referring to the reason that you are here, what part of your body is affected?left....right..... _____

Referring to the reason that you are here, how severe is the problem? mild.....moderate.....severe..... _____

Referring to the reason that you are here, how long has this been going on? _____

What makes the problem better? _____ What makes it worse? _____

How often does the problem happen?continuously.....daily.....weekly.....monthly.....yearly..... _____

How long does the problem usually last? _____

Are there any associated problems? _____

Have you had the same or a similar problem previously? _____

Have you ever been seen by a urologist for this problem? _____ What was the urologist's name? _____
 What year were you evaluated by the urologist? _____ What did the urologist's diagnosis? _____
 Which treatment worked? _____ Which treatment did not work? _____

Review of Systems

Have you had any of the following list of problems lately? Check the appropriate boxes.

- | | | |
|---|--|--|
| <input type="checkbox"/> Fever (temperature greater than 100.3 degrees) | <input type="checkbox"/> Fainting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Abnormal skin | <input type="checkbox"/> Very easy bruising | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Severe anxiety | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Blood in the urine that you can see | | |
| <input type="checkbox"/> Blood in the sputum or coughing-up blood | <input type="checkbox"/> Constipation (hard stool) or difficulties passing stool | |
| <input type="checkbox"/> Blood in the stool or black discolored stool | <input type="checkbox"/> Pain in leg muscles when you walk which goes away with rest | |

If you check a red box, fill in ALL of the questions beneath the box.



(If you check this, please answer ALL of the questions within the red box below.)

Is this getting better or worse? _____
 On a 1-10 scale, how bad is this or how much does the leakage bother you? (1 means little bother and 10 mean severe problem)1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....
 Does the urge to urinate cause you to leak urine (for example -- leaking or wetting on the way to restroom)? _____
 Do you accidentally leak urine when performing physical activities? _____
 Circle physical activities which causes leakage?.....cough.....sneeze.....strain.....laugh.....exercise.....walk.....other.....
 Which type of leakage is worse for you? leakage with physical activity (or) leakage with sudden urge to urinate

- Premature ejaculation -- please explain: _____
 Erection trouble, problems with erections/hardness of the penis, erectile dysfunction or impotence.

(If you check this, please answer ALL of the questions within the red box below.)

Is this getting better or worse? _____ Did you know that this can be effectively treated? _____
 Would you like to discuss treatment with Dr. Watson? _____ **If yes, please complete ALL of these questions.**
 When did this first start? _____
 On 1-10 scale, how bad is this or how much does this bother you?(1 means little bother, 10 mean severe problem)
1.....2.....3.....4.....5.....6.....7.....8.....9.....10.....
 Did this start about the same time that you started a new medication or changed medications? _____
 Does the penis become as firm or hard as it should? _____
 Do you tend to lose the erection during intercourse, even before climax? _____
 When this problem first started, was the penis curved, bent or crooked when it was fully erect? _____
 Do you currently have a sex partner? _____ Is your partner is supportive of you about this problem? _____
 How is your libido or sex drive?weak.....normal.....strong.....
 Do you think that your week libido or week sex drive is caused by the erection problem? _____

Circle a number in every row in the table below concerning how you have been urinating within the last week.

	Never (0)	Almost never (1)	Less than half the time (2)	About half the time (3)	More than half the time (4)	Almost always (5)
Incomplete Emptying -- After urinating, how often does your bladder still feel like it may not be empty?						
Frequency -- How often do you have very frequent urinating?						
Intermittency -- How often does your urine stream stop-and-restart while urinating?						
Urgency -- How often do you have a difficult to control urge to urinate?						
Weak Stream -- How often do you have a weak or slow urine stream?						
Hesitancy -- How often do you have trouble getting the urine stream started?						
Nocturia -- How many times do you most typically get up from sleep to urinate?		One time only (1)	Two times (2)	Three times (3)	Four times (4)	Five or more (5)

Total AUASS _____

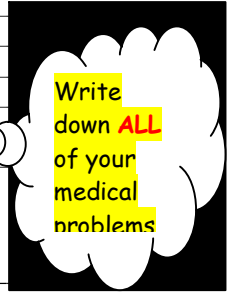
Surgical History

Please list every surgery that you have ever undergone.

Medical History

Please list any and every medical problem and diagnosis which you have been given by a doctor.

Include all heart, lung, kidney, blood pressure, stroke, cancer, diabetes, urology and all other medical problems.



Medications

List all of your medicine here.

Are you allergic to any medication or allergic to IV contrast/dye?

Family History

Have any of your blood relatives had these or other diseases?

- Diabetes
- Prostate cancer
- None -- No medical problems run in family.

List other family medical problems here.

Other Concerns

Are there any other problems about which you are concerned?

Social History

What city or town do you live in? _____ Where did you grow up? _____

What kind of work do you do presently? _____

Does your job require heavy physical activity? _____

What type of physical activity or exercise do you regularly perform? _____

If you are in school, where do you attend and what do you study? _____

Are you **married**? _____ How many **children** do you have? _____

Are you sexually active? _____ (That is, do you currently have a partner with whom you have intercourse?

The answer to this question is very important as it pertains to certain urological conditions such as cystitis, infections, prostatitis, sexual dysfunction, incontinence and many others. All answers are confidential to your medical record!)

Do you **smoke**? _____ Have you ever smoked? _____ How long ago did you stop smoking? _____

Do you drink coffee, "cokes" or tea which contain **caffeine**? _____ How much? _____

Do you drink **alcohol**? _____ How much can you/do you drink? _____

Do you use or smoke any illegal "street" drugs? _____

STOP HERE -- PLEASE DO NOT WRITE BELOW THIS LINE -- STOP HERE -- PLEASE DO NOT WRITE BELOW THIS LINE --
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MALE (1 -- 3 -- 9+3 -- 9+11 -- 9+11)

- testes: bilaterally descended, normal volume, no gross dissymmetry, no masses, nontender _____
- _____
- scrotum: normally developed, non-discolored, no crepittance, no lesions, no cysts, no rashes _____
- _____
- epididymis: bilaterally without gross dissymmetry, normal volume, no masses, no unusual tenderness _____
- _____
- phallus: normal male, normal meatus, normal sensory, (circ/non-circ), no significant phimosis, no palpable plaque, no masses _____
- _____
- meatus: normal size and location, no lesions, no discharge _____
- perineum: no masses, nontender, normal anus _____
- prostate: nonnodular, nontender, symmetric, nonfluctuant, approximately _____ grams _____
- seminal vesicles: bilaterally probably normal, nontender, no masses _____
- rectum: no masses, nontender, normal sphincter tone, no significant hemorrhoids, non-bloody stool _____

GENERAL

- GEN: well-developed, well nourished, no acute distress, no gross bodily deformities, respiratory rate normal, pulse rate normal and regular, temperature normal _____
- GI: abdomen without masses, nondistended, nontender, no organomegaly, no hernia _____
- HEENT: normocephalic _____
- eyes: normal appearing, no color change _____
- neck: normal appearing, supple, no increased jugular venous distention, no thyroid masses, no masses _____
- lungs: CTA bilaterally, no WRR, normal respiratory excursions _____
- cardiovascular: RRR, no MRG, radial and popliteal pulses three plus bilaterally, no significant pretibial nor presacral edema no carotid bruits _____
- chest: normal, no masses, nontender _____
- lymph: no adenopathy of the neck, axilla, growing or other location _____
- musculoskeletal: no orthopedic abnormalities, no midline defects, no edema, no CVA tenderness _____
- _____
- extremities: no clubbing, cyanosis nor edema, no orthopedic abnormalities _____
- psychiatric: oriented to PPTS, normal thought content, no suicidal ideation, mood appropriate for situation _____
- _____

ASSESSMENT: _____

PLAN/RECOMMENDATION: _____

- The patient/parent(s)/guardian(s) read and signed CONSENT form(s) for the procedure(s) performed or proposed as outlined above or dictated. ALL questions were answered to the satisfaction of all parties present, prior to proceeding with the procedure(s).
- The above described or dictated COUNSELING session and visit lasted for _____ minutes and the majority of this time was spent counseling.
- All images regarding the RADIOGRAPHIC STUDIES described herein and dictated were comprehensively reviewed for urology specific reasons for evaluation and treatment including possible surgical planning. A separate report of these findings is dictated.
- The RISKS, potential BENEFITS and all OPTIONS (including the options for no treatment) for the procedure(s) performed or proposed as outlined above or dictated, were discussed with the patient/parent(s)/guardian(s) in detail to the satisfaction of all parties present. There are no exceptions except as written here: _____
- The absolute requirement for close and careful medical and urological FOLLOW-UP (for lifelong basis in the case of known or suspected cancer/tumor, stone, neurologic disease and other chronic conditions) was emphasized and the patient's/parent(s)/guardian(s)' responsibility for such was defined clearly in understandable layman's terms. The risks of failure to do so were described and emphasized.
- The EVALUATION and TREATMENT PLANS were discussed with the patient/parent(s)/guardian(s) in understandable layman's terms and all parties present expressed their understanding, agreement, responsibility and request to proceed as outlined above or dictated. Exceptions are none, unless written here: _____

H. Stephen Watson, M.D.