Patient Information

(PLEASE PRINT LEGIBLY)

Name _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State ___ Zip Code _____

Street Address (if different) _____ City _____ State _____

Zip Code _____ Email _____ SS# _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status ___S ___ M___ D___ W Spouse's Name _____

Employers Name and Address _____

Preferred Pharmacy/Location _____ Phone _____

Emergency Contact Name _____ Phone _____

Insurance Information

Primary _____ Secondary _____

ID Number _____ ID Number _____

Group Number _____ Group Number _____

Insured Name (if different than patient or if patient is a minor)

Name _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State ___ Zip Code _____

Relationship to Patient _____

Referral Management

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

How Did You Hear About Us? _____

I hereby authorize Advanced Urological Care to provide medical treatment services to me and/or my dependents, and to use my Personal Health Information to file a claim for service with my insurance company. In doing so, I assign to the physician all payments for medical services provided. I understand that I am responsible for any amount not covered by my insurance. I also understand that if I do not have insurance, I am responsible for all charges associated with my visit and that payment is due at the time of my visit.

Signature _____ Date _____

Patient Name _____ Date _____

MEDICAL HISTORY

(PLEASE PRINT LEGIBLY)

Surgical Procedures

Type of surgery Year Hospital Surgeon

_____
_____
_____
_____
_____

Current Medications & Dosage

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies & Reactions

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family History

Bedwetting ___ Yes ___ No Who? _____ Age at onset _____
Diabetes ___ Yes ___ No Who? _____ Age at onset _____
Kidney Stones ___ Yes ___ No Who? _____ Age at onset _____
Prostate Cancer ___ Yes ___ No Who? _____ Age at onset _____

Social History

Have you smoked tobacco products? ___ Yes ___ No Current User _____ Former User _____
How many years did, or have you smoked? _____
Do you use caffeine? ___ Yes ___ No If yes, how many cups per day? _____
Do you drink alcohol? ___ Yes ___ No If yes, describe use: _____ Mild _____ Moderate _____ Heavy
Travel Overseas? ___ Yes ___ No When _____ Where _____
Are you retired? ___ Yes ___ No ___ Semi
Occupation _____
Are your parents living? ___ Yes ___ No
If not, age and cause of death: Mother _____ Father _____

Women ONLY Health Section

Number of children _____
Are you on Birth Control? ___ Yes ___ No
Do you have painful Periods? ___ Yes ___ No
Number of Pregnancies _____
Do you have irregular Periods? ___ Yes ___ No
Are you sexually active? ___ Yes ___ No

Authorization for Vasectomy

I, _____ authorize Dr. Simon to perform a Vasectomy on myself. I understand the operation consists of removing a section of the Vas Deferens (tube that carries sperm). I understand that once the Vasectomy is performed, it may not be reversible, despite the operations that are designed to do that.

I also understand that the operation is not guaranteed to result in sterilization (inability to father children). In a very small percentage of patients the divided ends of the Vas Deferens have reopened by themselves resulting in an unexpected pregnancy. I understand that other complications such as Hemorrhage, Infection, Pain, and swelling rarely occur.

I understand this is a 45-minute procedure. If the appointment needs to be changed or cancelled, we require a 48-hour notice. If this notice is not given, there will be a $100.00 charge. We regret the necessity of this charge however, we can not schedule another surgery on short notice.

Warning

If you have questions as to the risks, complications or hazards of the proposed surgery, ASK NOW BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN UNLESS YOU HAVE READ AND UNDERSTAND THIS FORM.

Medications	Allergies
_____	_____
_____	_____

Number of Children _____

Have you had any of the following:

- Chest Pain
- Kidney Infection
- Rheumatic Fever
- Shortness of Breath
- Venereal Disease
- Fainting Spells
- Bleeding Problems
- High Blood Pressure
- Asthma
- Diabetes
- Epilepsy

___ Yes, I am required to take an antibiotic prior to any dental work I have done.

_____ _____

Patient's Signature Wife's Signature (If appropriate)

_____ _____

Physician's Signature Date

Patient Name_____ Date_____

PAST MEDICAL HISTORY

Please check all that apply

	Onset date MM/YY		Onset date MM/YY
___ Abdominal Aortic Aneurysm	_____	___ DVT (blood clot in legs)	_____
___ Alcohol Withdrawal	_____	___ Dyspareunia (painful intercourse)	_____
___ Anemia	_____	___ Elevated Blood Pressure	_____
___ Angina Pectoris (chest pain)	_____	___ Elevated Prostate Specific Antigen	_____
___ Aortic Valve Disease	_____	___ Emphysema	_____
___ Aortic valve replacement	_____	___ Fibromyalgia	_____
___ Appendicitis	_____	___ Frequent UTIs	_____
___ Asthma	_____	___ Gastro Esophageal Reflux-GERD	_____
___ Backache	_____	___ Glaucoma	_____
___ Bladder Cancer	_____	___ Head Injury	_____
___ BPH (enlarged prostate)	_____	___ Heart Disease	_____
___ Breast Neoplasm, Malignant	_____	___ Heart Failure	_____
___ Bronchitis	_____	___ Hematuria (blood in urine)	_____
___ Cardiac Dysrhythmia(irregular heartbeat)	_____	___ Hepatitis	_____
___ Carotid Stenosis	_____	___ HIV/AIDS	_____
___ Cataracts	_____	___ Hormone Replacement Therapy	_____
___ Cervical Cancer	_____	___ Incontinence(leakage)	_____
___ Cesarean Delivery	_____	___ Infection of Kidney	_____
___ Cholelithiasis (gall stones)	_____	___ Kidney Stones	_____
___ Chronic Prostatitis	_____	___ Kidney X-ray (IVP)	_____
___ Chronic Renal Failure	_____	___ Mitral Valve Repair	_____
___ Coagulation Defect (bruise easily)	_____	___ Multiple Sclerosis	_____
___ Colitis, Ulcerative	_____	___ Myocardial Infraction (heart attack)	_____
___ Colon Cancer	_____	___ Neuropathy	_____
___ Congestive Heart Failure	_____	___ Nocturnal Enuresis	_____
___ COPD	_____	___ Parkinson's Disease	_____
___ Crohn's Disease	_____	___ Peripheral Vascular Disease	_____
___ CVA (stroke)	_____	___ Prostate Cancer	_____
___ Cystitis (bladder infections)	_____	___ Senile Dementia	_____
___ Cystocele	_____	___ Sleep Apnea	_____
___ Cystoscopy	_____	___ Testicular Cancer	_____
___ Diabetes Mellitus, Type I IDDM (insulin dependent)	_____	___ Urethral Stricture	_____
		___ Other	_____
___ Diabetes Mellitus, Type II	_____	___ Other	_____

Patient Name _____ Date _____

Reason for Visit

(PLEASE PRINT LEGIBLY)

Chief Complaint

What is the main reason for your visit today? _____

Have you ever seen a Urologist before? ___Yes ___ No If yes, who and When? _____

If male, have you had a PSA blood test? ___ Yes ___ No If yes, please list result and date _____

History of Present Illness

When did you first notice the problem? Date: (MM/YY) _____

Is the problem continuous or does it come and go? _____

Does anything make your problem worse or better? ___ Yes ___ No Which? ___ Worse ___ Better

Review of Systems

Do you currently have any problems listed below: (Please Check One)

Constitutional Symptoms	
Weight Loss	___ Yes ___ No
Fever	___ Yes ___ No
Chills	___ Yes ___ No
Other	___ Yes ___ No
Eyes	
Blurred Vision	___ Yes ___ No
Eye Pain	___ Yes ___ No
Other	___ Yes ___ No
Cardiovascular	
Chest Pain	___ Yes ___ No
Rapid Heartbeat	___ Yes ___ No
Other	___ Yes ___ No
Respiratory	
Shortness of Breath	___ Yes ___ No
Frequent Cough	___ Yes ___ No
Other	___ Yes ___ No
Gastrointestinal	
Constipation	___ Yes ___ No
Diarrhea	___ Yes ___ No
Abdominal Pain	___ Yes ___ No
Vomiting	___ Yes ___ No
Other	___ Yes ___ No

Genitourinary	
Blood in Urine	___ Yes ___ No
Urinary Frequency	___ Yes ___ No
Burning on Urination	___ Yes ___ No
Urinary Leakage	___ Yes ___ No
Bedwetting	___ Yes ___ No
Difficulty with Intercourse	___ Yes ___ No
Other	___ Yes ___ No
Neurological	
Tremors	___ Yes ___ No
Loss of Balance	___ Yes ___ No
Memory Loss	___ Yes ___ No
Other	___ Yes ___ No
Musculoskeletal	
Joint Pain	___ Yes ___ No
Bone Pain	___ Yes ___ No
Back Pain	___ Yes ___ No
Other	___ Yes ___ No
Endocrine	
Heat Intolerance	___ Yes ___ No
Cold Intolerance	___ Yes ___ No
Increased Thirst	___ Yes ___ No
Other	___ Yes ___ No
Hematologic	
Easily Bruised	___ Yes ___ No
Swollen Lymph Nodes	___ Yes ___ No
Easy Bleeding	___ Yes ___ No
Other	___ Yes ___ No

Advanced Urological Care

Vasectomy Information

You are scheduled for your vasectomy on _____ at _____ pm. Please arrive 10 minutes prior to your procedure time.

Dr. Simon will be doing your procedure at Dr. Aaron Smith's office, located at:
5901 Corporate Drive. Colorado Springs, CO 80919.

We are unable to accept payment at this location. Therefore, full payment must be made at Advanced Urological Care prior to your procedure.

Vasectomy Preparation

- Sign a consent form. This must be done at least a few days before surgery. It gives your doctor permission to do the procedure. It also states that a vasectomy is not guaranteed to make you sterile.
- Tell your doctor if you've had any scrotal surgery in the past.
- Shower, shave and clean your scrotum the day of surgery.
- Bring a jock strap (athletic supporter) or pair of snug cotton briefs to the doctor's office or hospital.

During Surgery

- The entire procedure usually lasts 45 minutes.
- You'll be asked to undress and lie on a table.
- To prevent pain during surgery, you'll be given a local anesthesia injection in the scrotal area.
- makes one or two small incisions in the scrotum. This may be done with a scalpel or with a pointed clamp (no-scalpel method).
- The vas deferens are lifted through the incision and cut. The provider seals off the ends of the vas deferens using one of several methods.
- The incision is closed with stitches that will dissolve in 5-7 days.
- You can rest for a while until you're ready to go home.

Post-Operative Vasectomy Patient Instructions

(1) Lie flat or in an easy chair with your feet up for the remainder of the day of your surgery. Rest for the next 2-3 days, keeping your legs up as much as possible. Gradually resume routine activities over the next 2 weeks. Avoid climbing, running, lifting over 25 pounds or heavy exercise for 1-2 weeks.

(2) Apply ice packs to the scrotal area for 10-15 minutes every 2 hours during the first and second day of the surgery. This will help reduce pain and swelling.

(3) After surgery, a gauze dressing will be on the surgical site. Leave this in place for 24 hours. You should use a small dressing for several days after this, a small amount of Neosporin or similar will help the gauze stick to the wound.

(4) Continue to wear athletic supporter (Jock Strap) day and night for 72 hours after the following surgery. Wearing the Jock Strap tightly the first day will help prevent any bleeding complications. The Jock Strap may be worn for the next week for comfort and support.

(5) You may take Tylenol or Vicodin every 4 hours for pain (**do not take Tylenol and Vicodin at the exact same time since they both contain acetaminophen).** Avoid Aspirin or other anti-inflammatory medications such as Ibuprofen/Motrin or Naproxen/Aleve for several days after surgery to minimize bleeding risks.

(6) If you notice bleeding at the incision site, cover your hand with sterile gauze and gently apply pressure or pinch the area for 5-10 minutes. Notify your physician if the bleeding continues.

(7) You may carefully shower 24 hours after the surgery, do not take tub baths or swim for at least one week after the surgery.

(8) Do not ejaculate one week after the surgery, you may gradually resume sexual activity after 1-2 weeks.

(9) You must use condoms or some other form of birth control until examination of two semen specimens show no sperm.

(10) Semen checks will be done approximately 6-8 weeks after your procedure. You should ejaculate at least 15 times in the weeks prior to the first check. Samples should be collected in a clean plastic container and be submitted into the office. Call ahead to assure the doctor will be in that day.

(11) Please call 719-387-1535 if you have a fever, bleeding, persistent or worsening pain, or other problems. Some bruising is usually normal and will go away within several weeks.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Protected health information (PHI) will be disclosed or used by Advanced Urological Care for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations.

I understand that I have a right to request restrictions of the uses and disclosures of my PHI for the above stated purpose.

I understand I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

We may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. Any message we leave may contain confidential information not intended for others. To avoid any breach in confidentiality, please review the choices below and check those that apply:

___ Yes, the doctor's office may email me.

___ Yes, the doctor's office may leave messages on my answering machine/voice mail.

___ No, do not leave messages. ___ I have no answering machine.

In some cases, it is helpful for a spouse, family member, or trusted friend to be informed of your medical care, to include test results. Pease mark yes or no below.

___ No, do not discuss my medical care with anyone other than myself.

___ Yes, your office may discuss my medical care with the following people:

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Signature of Patient/Guardian _____ Date _____