Siouxland Urology Associates
455 Sioux Point Road
Dakota Dunes, SD 57049
Phone: 605-217-7000 Fax 605-217-7015

Kenneth E. McCalla, MD
Timothy G. Kneib, MD
Craig A. Block, MD
Andrew E. Bourne, MD
David H. Daniels II, MD

Kathryn T. Kassin, PA-C
Patrick J. Honner, PA-C
Luke M. Sachau, PA-C
Chad P. Millikan, APRN-C
Sarah M. Brend, PA-C

Last Name: _____ First Name: _____ Middle: _____
Social Security Number: _____Date of Birth: ____/____/____ Sex: M F Marital Status: M S W D
Address: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Emergency Contact: _____

Insurance Authorization:
I authorize release of information to my insurance companies. I understand I am responsible for my bill. I authorize payment directly to my physician. I authorize use of this form on all of my insurance submissions. I authorize this practice to act as my agent to help me secure payment from my insurance companies. I will notify the physician's office if a second opinion or prior authorization is required.

_____ _____
Date Signature of Patient or Responsible Party

The main reason for seeing the doctor: _____

Referring Doctor: _____ Family Doctor: _____

Allergies: To medication and any other allergies
_____ _____
_____ _____

Pharmacy: _____

Medications: _____
_____
_____

Surgical History: Please list any surgeries and approximate dates
_____ _____
_____ _____
_____ _____

Past Medical History: (Circle all that apply) – these are examples, please write others below
Do you or have you had:
Stroke, diabetes, thyroid abnormalities, high blood pressure, lung cancer, lung problems, heart attack or heart problems, rheumatic heart disease, hepatitis, colitis or bowel problems, bleeding disorders, spinal cord injury, significant injuries, cancers, depression/anxiety, high cholesterol, MRSA, VRE
Other Significant history: _____

Urologic History: Have you had: (Circle all that apply)
Urinary tract infections, hematuria (blood in urine), IVP's (kidney x-rays), prostatitis, vasectomy, kidney stones, abnormal PSA, enlarged prostate,
cancer of the kidney, bladder, prostate or testicle

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surgery of the kidney, bladder, prostate or testicle
Any others (please list) _____

Family History: (List who)
Prostate Cancer_____
Cancer (of any kind)_____
Diabetes_____
Bleeding disorders_____
Kidney Disease _____
Kidney Stones_____
Heart Disease_____
Bedwetting_____
High blood pressure_____
Any other pertinent family history _____

Habits: Are you a smoker: YES NO (If yes, packs per day _____)
If you quit, how long ago: _____
Do you drink alcohol? YES NO (If yes, number of cups per day_____)
Do you drink caffeinated beverages? YES NO (If yes, number of cups per day_____)

Social History: List your occupation and work phone number: _____
(If retired, list previous occupation) _____
Race: _____ Ethnicity: _____ Language: _____

Could you be pregnant? YES NO Are you on birth control? YES NO If yes, please list method: _____
Number of deliveries _____ Number of C Sections _____ Have you had a hysterectomy or bladder tied up? (Circle if applies)
Please list approximate height _____ weight _____
Have you been seen in his clinic before? YES NO If yes, approximately when, and for what? _____

REVIEW OF SYSTEMS: Are you currently having problems with any of the following (Please circle):

CONSTITUTIONAL	**NEUROLOGICAL (CONTINUED)**	**CARDIOVASCULAR (CONT)**	**ENDOCRINE**
Aches/Pains	Tremors	Heart failure	Diabetes
Appetite Changes	Leg or Arm weakness	Heart murmur	Pituitary disease
Bruises easily	Memory Loss	High blood pressure	Thyroid disease
Fever	Speech problems	Irregular heart beat	Excess thirst
Chills	Other	Low exercise tolerance	Tired/sluggish
Hot Flashes		Mitral valve prolapse	Heat/cold intolerance
Fatigue	**GASTROINTESTINAL**	Pain/cramps	Other
Generalized Weakness	Acid Reflux	Palpitations	
Insomnia	Indigestion/Heartburn	Shortness of breath	**RESPIRATORY**
Swollen Glands	Nausea/Vomiting	Skipped heart beats	Asthma
Weight loss	Abdominal pain	Swelling	Tuberculosis
Weight gain	Bloody stools	Other	Emphysema-bronchitis
Other	Abdominal cramps		Environmental allergies
	Diarrhea	**MUSCULOSKELETAL**	Frequent cough
ALLERGIC/IMMUNOLOGIC	Constipation	Back Pains	Shortness of breath
Seasonal	Change bowel habits	Joint Pains	Wheezing
Drug	Hemorrhoids	Neck pain/stiffness	Other
Animal	Gas	Muscle cramps	
Environmental	Rectal bleeding	Arthritis	**HEMATOLOGIC/LYMPHATIC**
Other	Tarry stools	Muscle weakness	Swollen glands
	Other	Other	Bleeding problems
NEUROLOGIC			Hepatitis
Stroke	**CARDIOVASCULAR**	**EAR/NOSE/THROAT**	HIV/(AIDS)
Headache	Chest pain/angina	Ear infection	IV Drug use
Dizzy spells	Edema/swelling	Sinus problems	Sickle Cell
Balance problems	Hardening of arteries	Sore throat	Other
Numbness/Tingling	Heart Attack	Other	

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