

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) _____
 Past PSA? _____ Value: _____

Family History: (List who) _____ Kidney Disease _____
 Prostate Cancer _____ Kidney Stones _____
 Cancer (of any kind) _____ Heart Disease _____
 Diabetes _____ Bedwetting _____
 Bleeding disorders _____ 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: _____

Do you have trouble with impotence (erections)? YES NO If yes, are you interested in treatment? YES NO

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):

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