SIOUXLAND Urology ASSOCIATES P.C.

455 Sioux Point Road
Dakota Dunes, SD 57049 (605) 217-7000

Timothy G. Kneib, M.D., F.A.C.S.
Craig A. Block, M.D., F.A.C.S.
Andrew E. Bourne, M.D., F.A.C.S.
David H. Daniels II, M.D., F.A.C.S.
Jamie L. Olsen, D.O., F.A.C.S.
Adam B. Althaus, M.D.

Lukas M. Sachau, PA-C
Sarah M. Brend, PA-C
Chad P. Millikan, APRN-C
Tara Liddiard, APRN-C
Rebecca Luebbert, PA-C

PATIENT INFORMATION FORM

Date _____

_____ Last Name _____ First Name _____ Middle Name

_____ Social Security Number ____/____/____ Date of Birth _____ Age M F Sex M S W D Marital Status

_____ Address: Street and/or P.O. Box # _____ City, State and Zip Code

_____ Cell Phone Number _____ Home Phone Number _____ E-mail Address

Employment Status: _____ (Occupation)

_____ Employed By _____ Employer's Address _____ Business Phone Number

Next of Kin: Name_____ Relationship _____

Address and Phone_____

INSURANCE INFORMATION — Please Show Receptionist Your Cards

Medicare Number _____

Blue Shield Number _____ Group # _____ State _____

Other Insurance _____ Insurance Company Name _____ Address (City, State and Zip Code)

_____ Policy Number _____ Group Name and Number

Title XIX Number _____ County _____

Any additional insurance information, please notify the receptionist at this time.

PLEASE NOTE: WE MUST HAVE THE SOCIAL SECURITY NUMBER AND DATE OF BIRTH ON ALL POLICY HOLDERS IF OTHER THAN THE PATIENT.

_____ Social Security # of Policy Holder _____ Date of Birth of Policy Holder

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

_____ Date X _____ Signature of Patient or Responsible Party

THE ABOVE INFORMATION WAS VOLUNTARILY GIVEN AND IS TRUE AND CORRECT

X _____ Signature of Patient or Legal Guardian

PLEASE INFORM US IF YOUR INSURANCE REQUIRES SECOND OPINION OR PRIOR AUTHORIZATION

PATIENT INFORMATION

The main reason for seeing the doctor: _____

_____

Referring Doctor: _____ Primary Doctor: _____

Urologic History: Have you had? (circle all that apply)

Urinary tract infections, hematuria (blood in urine), IVP's (kidney x-rays), incontinence, kidney stones, cancer of the kidney, bladder, urethra or vagina, surgery of the kidney, bladder, uterus, urethra or vagina

Any others (please list) _____

_____

Past Medical History: (Circle all that apply)

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, infections

Have you ever had a colonoscopy? If yes, when? _____

Have you ever had the pneumonia vaccine? If yes, when? _____

Other significant history: _____

_____

Surgical History: Please list any surgeries and approximate dates (if not listed above)

_____ _____

_____ _____

_____ _____

_____ _____

Medications: Please list all medications including aspirin, vitamins & antibiotics & dosages

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy: _____ _____ _____

Allergies: To medication and any other allergies

Reactions:

_____ _____

_____ _____

_____ _____

Habits: Do you smoke? YES NO (If yes, packs per day _____)

Do you drink alcohol? YES NO (If yes, # of alcoholic beverages per day _____)

Do you drink coffee? YES NO (If yes, # of cups per day _____ REGULAR DECAF)

Family History: (List who)

Prostate cancer _____ Kidney disease _____

Cancer (of any kind) _____ Kidney stones _____

Diabetes _____ Heart disease _____

Bleeding disorders _____ Bedwetting _____

Any other pertinent family history _____ High blood pressure _____

Social History: List your occupation _____

(If retired, list previous occupation) _____

Current Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race:_____ Ethnicity_____ Preferred Language:_____

Please list approximate Height _____ Weight _____

Have you ever been seen in this clinic before? ☐Yes ☐No If yes, approximately when and what for:

_____

_____

Review of Systems:

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

Constitutional
Aches/Pains
Appetite Changes
Bruises easily
Fever
Chills
Hot Flashes
Fatigue
Generalized Weakness
Insomnia
Swollen Glands
Weight loss
Weight gain
Other

Allergy/Immunologic
Seasonal
Drug
Animal
Environmental
Other

Neurological
Stroke
Headache
Dizzy spells
Balance problems
Numbness/Tingling

Neurological (continued)
Tremors
Leg or Arm weakness
Memory Loss
Speech problems
Other

Gastrointestinal
Acid Reflux
Indigestion/Heartburn
Nausea/Vomiting
Abdominal pain
Bloody stools
Abdominal Cramps
Diarrhea
Constipation
Change bowel habits
Hemorrhoids
Gas
Rectal Bleeding
Tarry stools
Other

Cardiovascular
Chest pain/angina
Edema/Swelling
Hardening of arteries
Heart Attack

Cardiovascular (cont.)
Heart Failure
Heart Murmur
High blood pressure
Irregular heart beat
Low exercise tolerance
Mitral Valve Prolapse
Pain/Cramps
Palpitations
Shortnesss of breath
Skipped heart beats
Swelling
Other

Musculoskeletal
Back pains
Joint pains
Neck pain/stiffness
Muscle cramps
Arthritis
Muscle weakness
Other

Ear/Nose/Throat
Ear infection
Sinus Problems
Sore Throat
Other

Endocrine
Diabetes
Pituitary Disease
Thyroid Disease
Excess thirst
Tired/Sluggish
Heat/Cold Intolerance
Other

Respiratory
Asthma
Tuberculosis
Emphysema-Bronchitis
Environmental allergies
Frequent cough
Shortness of Breath
Wheezing
Other

Hematological/Lymphatic
Swollen Glands
Bleeding Problems
Hepatitis
HIV/ (AIDS)
IV Drug Use
Sickle Cell
Other

Could you be pregnant? YES NO

Are you on birth control? YES NO

If yes, please list method:_____

Number of vaginal deliveries _____ Number of C Sections _____

Have you had a hysterectomy or bladder tied up? (Circle if applies)

Pelvic Health and Bladder Survey

Name_____ **Date**_____

Which symptoms best describe you? Check all that apply.

- ❑ Frequent Urination – Day, Night, and/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 bladder – Feels like there is more even after voiding
- ❑ Accidental leakage with physical activity like exercising, sneezing or coughing
- ❑ Bladder or Pelvic Pain
- ❑ No Bladder Problems (no need to continue survey)

How long have you had any of the above symptoms?_____

Which symptom is the most bothersome to you?_____

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

If yes, check the medications you have tried:

❑ Detrol LA	❑ Elavil	❑ Myrbetriq	❑ Sanctura XR	❑ Other_____
❑ Ditropan XL	❑ Elmiron	❑ Oxybutynin	❑ Toviaz	
❑ Enablex	❑ Gelnique	❑ Oxytrol Patch	❑ Vesicare	

How much symptom relief have these medications provided for you? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

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 taken medications ❑ Other

If side effects or other, please explain:_____

Behavioral modifications tried?_____
(i.e.–reduced fluid intake; caffeine reduction; Kegel exercises, physical therapy; lifestyle changes)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Very Frustrated***

Do you currently have any problems with bowel function?

❑ Loss or Leakage of Stools ❑ Constipation ❑ Other ❑ None

Are you interested in learning more about additional treatment alternatives to bladder medications? ❑ Yes ❑ No

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

Timothy G. Kneib, MD
Craig A. Block, MD
Andrew E. Bourne, MD
David H. Daniels II, MD
Jamie L. Olsen, DO

Adam B. Althaus, MD

Chad P. Millikan, FNP-C
Luke M. Sachau, PA-C
Rebecca E. Luebbert, PA-C
Sarah M. Brend, PA-C

Tara L. Liddiard, APRN-C

PATIENT INFORMATION FORM Date: _____

Last Name _____ First Name _____ Middle Name _____

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

Have you ever had a colonoscopy? _____ When? _____ Have you ever had a pneumonia vaccine If so, when? _____

Do you smoke? _____ If yes, how many packs a day? _____

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

CONSTITUTIONAL
Aches/Pains
Appetite Changes
Bruises easily
Fever
Chills
Hot Flashes
Fatigue
Generalized Weakness
Insomnia
Swollen Glands
Weight loss
Weight gain
Other

ALLERGIC/IMMUNOLOGIC
Seasonal
Drug
Animal
Environmental
Other

NEUROLOGIC
Stroke
Headache
Dizzy spells
Balance problems
Numbness/Tingling

NEUROLOGICAL (CONTINUED)
Tremors
Leg or Arm weakness
Memory Loss
Speech problems
Other

GASTROINTESTINAL
Acid Reflux
Indigestion/Heartburn
Nausea/Vomiting
Abdominal pain
Bloody stools
Abdominal cramps
Diarrhea
Constipation
Change bowel habits
Hemorrhoids
Gas
Rectal bleeding
Tarry stools
Other

CARDIOVASCULAR:
Chest pain/angina
Edema/swelling
Hardening of arteries
Heart Attack

CARDIOVASCULAR (CONT)
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

MUSCULOSKELETAL
Back Pains
Joint Pains
Neck pain/stiffness
Muscle cramps
Arthritis
Muscle weakness
Other

EAR/NOSE/THROAT
Ear infection
Sinus problems
Sore throat
Other

ENDOCRINE
Diabetes
Pituitary disease
Thyroid disease
Excess thirst
Tired/sluggish
Heat/cold intolerance
Other

RESPIRATORY
Asthma
Tuberculosis
Emphysema-bronchitis
Environmental allergies
Frequent cough
Shortness of breath
Wheezing
Other

HEMATOLOGIC/LYMPHATIC
Swollen glands
Bleeding problems
Hepatitis
HIV/(AIDS)
IV Drug use
Sickle Cell
Other

Could you be pregnant? YES NO
Are you on birth control YES NO

If yes, please list method: _____

Number of normal deliveries _____ Number of C Sections _____

Revised 03/17/2021

OVER

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

Timothy G. Kneib, MD
Craig A. Block, MD
Andrew E. Bourne, MD
David H. Daniels II, MD
Jamie L. Olsen, DO

Adam B. Althaus, MD

Chad P. Millikan, FNP-C
Luke M. Sachau, PA-C
Rebecca E. Luebbert, PA-C
Sarah M. Brend, PA-C

Tara L. Liddiard, APRN-C

Have you have a hysterectomy or bladder tied up? (Circle if applies)

Any new surgeries in the last 18 months? _____

Any new medical problems/hospitalizations? _____

Any new medications? _____
Any allergies? _____

Revised 03/17/2021

OVER