



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.
Jamie L. Olsen, D.O.
Adam B. Althaus, M.D.

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

PATIENT INFORMATION FORM

Date _____

Last Name First Name Middle Name

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

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) Kidney disease _____
Prostate cancer _____ Kidney stones _____
Cancer (of any kind) _____ Heart disease _____
Diabetes _____ Bedwetting _____
Bleeding disorders _____ High blood pressure _____
Any other pertinent family history _____

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
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

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
- Oxybutynin
- Toviaz
- Ditropan XL
- Elmiron
- Oxytrol Patch
- Vesicare
- Enablex
- Gelnique
- Sanctura XR
- Other _____

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

0	1	2	3	4	5	6	7	8	9	10
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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
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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