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

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Luke M. Sachau, PA-C
Rebecca E. Luebbert, PA-C
Sarah M. Brend, PA-C

Tara L. Liddiard, APRN-C

Adam B. Althaus, MD

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

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Any new surgeries in the last 18 months? _____

Any new medical problems/hospitalizations? _____

Any new medications/allergies? _____

SIOUXLAND Urology ASSOCIATES P.C.

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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), prostatitis, vasectomy, kidney stones, abnormal PSA, enlarged prostate, cancer of the kidney, bladder, prostate, or testicle

surgery of the kidney, bladder, prostate or testicle

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 & dosages

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy:

_____ _____ _____

Allergies: To medication and any other allergies

Reactions:

_____ _____

_____ _____

Habits: Are you a smoker? YES NO (If yes, packs per day _____)

If you have quit, how long ago? _____

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

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

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:_____

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 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

Men, please complete back page

FOR MALES ONLY

International Prostate Symptom Score (I-PSS)

Patient name:

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after your finished urinating	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 or more times	
7. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
Total I-PSS Score=							

Quality of Life Due to Urinary Symptoms

	Delighted	Pleased	Mostly satisfied	Mixed–about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications? ❑ Yes ❑ No