UROLOGICAL ASSOCIATES, P.C.
1644 Medical Center Pt., Suite 200
Colorado Springs, CO 80907
PH: 719-634-1994 FX: 719-622-6016

Adult & Pediatric Urology

Craig K. Carris, M.D., F.A.C.S.
Diplomate
American Board of Urology

Elliot J. Cohn, M.D.
Diplomate
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Benjamin J. Coons, M.D.
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Michael M. Crissey, M.D.
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J. Eric Derksen, M.D.
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Jeffrey K. Ferguson, M.D.
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James A. Simon, M.D.
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Joanna V. Jones, NP-C
AANP

Stacen G. Jones, MBA
Practice Manager

Vasectomy Patients Form

In order to ensure we meet with you on time, please have these pages completed. **Complete this form** by typing in the spaces with your answers. You will be instructed on the last page to save this form to your computer and email to our office as an attachment. Please bring your insurance card to your appointment. If you do not have insurance, we honor Visa, MasterCard, electronic checks and cash.

We are contracted with many insurance plans, however, in order to ensure our physician is listed on your insurance plan, please call your insurance company. **If you are covered by an HMO Plan, please contact your primary care physician to request that a referral be forwarded to our office, prior to your visit. If we do not receive a referral, your appointment may be rescheduled. Please be prepared to pay your co-payment or co-insurance at the time or your visit.**

We will call you prior to your visit to confirm the date and time of your appointment. If your schedule changes, please call our office to cancel your appointment. **If you do not give 24 hours notice of a cancellation, you will be billed $100.00.**

We are looking forward to meeting you. If you have any questions, please feel free to contact our office. Our hours are Monday-Friday from 9:00am-Noon and 1:30 until 4:30pm.

In compliance with HIPPA regulations, our office has the Notice of Privacy Practice (NPP) policies posted on our website (www.urologicalassoc.com) for your review or you may ask for a copy at the front desk.

Sincerely,

The Staff of Urological Associates, P.C.

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A Note To Our Vasectomy Patients

We are pleased you have chosen a physician at Urological Associates to perform your vasectomy. This letter is intended to provide you with additional information that many of our patients have found helpful.

We request that prior to coming to the office for the vasectomy that you shave the entire scrotum, (the area above the penis does not need to be shaved.) Please shower afterward to remove any loose hair. There is no need to fast prior to the procedure, although it is necessary to abstain from alcohol for 6 hours prior to the vasectomy.

The procedure is done using a local anesthetic, and mild sedation is often used. If you would like to have the sedation, please plan on having someone drive you home. It is a good idea to wear a snug pair of briefs or an athletic supporter to the procedure and to continue the use of the support until all swelling has resolved.

The office is working on making changes in our scheduling procedures so that the waiting period between the consultation and the vasectomy appointments can be shortened. Unfortunately, last minute cancellations continue to be a significant problem. We understand that circumstances can occur which necessitates canceling an appointment. We also understand that patients change their minds; however if a cancellation occurs less than 48 hours of the scheduled vasectomy, a fee of $100 will be charged. We appreciate your help with this aspect of our scheduling.

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Patient Information

DATE

NAME DATE OF BIRTH AGE

MAILING ADDRESS

CITY STATE ZIP

STREET ADDRESS *(IF DIFFERENT)* CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

SS# SEX (SELECT ONE) ◯M ◯F

EMPLOYER'S NAME AND ADDRESS

INSURED'S NAME (IF OTHER THAN PATIENT OR IF PATIENT IS A MINOR)

NAME DATE OF BIRTH

MAILING ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE SS#

RELATIONSHIP TO PATIENT MARITAL STATUS: ◯S ◯M ◯D ◯W SPOUSE'S NAME

EMPLOYER'S NAME AND ADDRESS

INSURANCE (PLEASE BRING YOUR DRIVERS LICENSE AND INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT)

PRIMARY:	SECONDARY:
COMPANY	
ID NO.	
GROUP NO.	

THE FOLLOWING INFORMATION IS MANDATORY

WHO IS THE PATIENT'S PRIMARY CARE PHYSICIAN? PHONE

NAME OF PHYSICIAN WHO REFERRED YOU HERE PHONE

EMERGENCY CONTACT NOT RESIDING WITH THE PATIENT PHONE

I hereby authorize Urological Associates, P.C. to provide medical treatment services to me and/or my dependents, and use my Personal Health Information to file a claim for service with your insurance company. In doing so, I assign to the physicians all payments for medical services provided. I understand that I am responsible for any amount not covered by my insurance. I also understand that if I do not have insurance, I am responsible for all charges associated with my visit to be paid in full on the day of my visit.

SIGNATURE DATE

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Patient Name _____ Date _____

Consent To Use And Disclose Protected Health Information

Protected health information (PHI) will be disclosed or used by Urological Associates for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations.

I understand that I have a right to request restrictions of the uses and disclosures of my PHI for the above stated purpose. But you are not required to agree with these restrictions.

If you would like to view the Notice of Privacy Practices for more detailed information just ask the receptionist for the binder with this information in it or you may view it on our website at www.urologicalassoc.com.

I understand I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Our office may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. These messages may contain confidential information not intended for others. To avoid any breach in confidentiality, please review the choices below and check those that apply:

◯ YES, THE DOCTOR'S OFFICE MAY LEAVE MESSAGES ON MY ANSWERING MACHINE/VOICE MAIL.

◯ NO, DO NOT LEAVE ANY MESSAGES. ◯ I HAVE NO ANSWERING MACHINE.

In some cases it is helpful for a spouse or family member to be informed of your medical care, to include test results. Please mark yes or no below.

◯ NO, DO NOT DISCUSS MY MEDICAL CARE WITH ANYONE OTHER THAN ME.

◯ YES, YOUR OFFICE MAY DISCUSS MY MEDICAL CARE WITH THE NAMES LISTED BELOW:

PHONE # _____ RELATIONSHIP TO PATIENT _____

NAME _____

SIGNATURE OF PATIENT / GUARDIAN DATE _____

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Patient Name Date

Past Medical History

Please check all that apply:

	Onset date MM/YY		Onset date MM/YY
☐ Abdominal Aortic Aneurysm		☐ DVT (blood clot in legs)	
☐ Alcohol Withdrawal		☐ Dyspareunia (painful intercourse)	
☐ Anemia		☐ Elevated Blood Pressure Rating	
☐ Angina Pectoris (chest pain)		☐ Elevated Prostate Specific Antigen	
☐ Aortic Valve Disease		☐ Emphysema	
☐ Aortic valve replacement		☐ Fibromyalgia	
☐ Appendicitis		☐ Frequent UTIs	
☐ Asthma		☐ Gastro Esophageal Reflux-GERD	
☐ Backache		☐ Glaucoma	
☐ Bladder Cancer		☐ Head Injury	
☐ BPH (enlarged prostate)		☐ Heart Disease	
☐ Breast Neoplasm, Malignant (cancer)		☐ Heart Failure	
☐ Bronchitis		☐ Hematuria (blood in urine)	
☐ Cardiac Dysrhythmia (irregular heartbeat)		☐ Hepatitis	
☐ Carotid Stenosis		☐ HIV / AIDS	
☐ Cataracts		☐ Hormone Replacement Therapy	
☐ Cervical Cancer		☐ Incontinence (leakage)	
☐ Cesarean Delivery		☐ Infection of Kidney	
☐ Cholelithiasis (gall stones)		☐ Kidney Stones	
☐ Chronic Prostatitis		☐ Kidney X-Ray (IVP)	
☐ Chronic Renal Failure		☐ Mitral Valve Repair	
☐ Coagulation Defect (bruise easily)		☐ Multiple Sclerosis	
☐ Colitis, Ulcerative		☐ Myocardial Infraction (heart attack)	
☐ Colon Cancer		☐ Neuropathy	
☐ Congestive Heart Failure		☐ Nocturnal Enuresis (bedwetting)	
☐ COPD		☐ Parkinson's Disease	
☐ Crohn's Disease		☐ Peripheral Vascular Disease	
☐ CVA (stroke)		☐ Prostate Cancer	
☐ Cystitis (bladder infections)		☐ Senile Dementia	
☐ Cystocele		☐ Sleep Apnea	
☐ Cystoscopy		☐ Testicular Cancer	
☐ Diabetes Mellitus, Type I, IDDM (insulin dependent)		☐ Urethral Stricture	
☐ D Diabetes Mellitus, Type II		☐ Other	
		☐ Other	

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Patient Name Date

Medical History

Please complete your past medical, social, and family history.

If male, have you had a PSA blood test? Y ◯ N ◯ If yes, please list result and date

Please list any surgical procedures:

TYPE OF SURGERY	YEAR	HOSPITAL	SURGEON

Please list all medicines and doses:

	MEDICINE	DOSAGE AMOUNT
1.		
2.		
3.		
4.		
5.		
6.		

Please list allergies/reactions to medications.

	ALLERGY	REACTION
1.		
2.		
3.		
4.		
5.		
6.		

Name and location of preferred pharmacy

Is there a family history of:

BEDWETTING	Y ◯	N ◯	WHO?	AGE AT ONSET?
DIABETES	Y ◯	N ◯	WHO?	AGE AT ONSET?
KIDNEY FAILURE	Y ◯	N ◯	WHO?	AGE AT ONSET?
KIDNEY STONES	Y ◯	N ◯	WHO?	AGE AT ONSET?
PROSTATE CANCER	Y ◯	N ◯	WHO?	AGE AT ONSET?

HAVE YOU SMOKED TOBACCO PRODUCTS? Y ◯ N ◯ CURRENT USER ◯ FORMER USER ◯

HOW MANY YEARS DID OR HAVE YOU SMOKED?

DO YOU USE CAFFEINE? Y ◯ N ◯ IF YES, HOW MANY CUPS PER DAY?

DO YOU DRINK ALCOHOL? Y ◯ N ◯ IF YES, DESCRIBE USE: MILD ◯ MODERATE ◯ HEAVY ◯

TRAVEL OVERSEAS? Y ◯ N ◯ WHEN? WHERE?

OCCUPATION

RETIRED? Y ◯ N ◯ SEMI ◯

ARE YOUR PARENTS LIVING? Y ◯ N ◯

IF NOT, AGES AT TIME OF DEATH AND CAUSE: Mother Father

Women Only Health Section

NUMBER OF CHILDREN NUMBER OF PREGNANCIES ARE YOU ON BIRTH CONTROL? Y ◯ N ◯

DO YOU HAVE IRREGULAR PERIODS? Y ◯ N ◯ DO YOU HAVE PAINFUL PERIODS? Y ◯ N ◯

ARE YOU SEXUALLY ACTIVE? Y ◯ N ◯

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Patient Name Date

Reason For Your Visit

Chief Complaint
What is the main reason for your visit today?

Have you ever seen a Urologist before? Y ○ N ○ IF YES, WHO & WHEN?

History of Present Illness:
WHEN DID YOU FIRST NOTICE THE PROBLEM? DATE: (MM/YYYY)
IS THE PROBLEM CONTINUOUS OR DOES IT COME AND GO?
DOES ANYTHING MAKE YOUR PROBLEM WORSE OR BETTER? Y ○ N ○ WHICH? WORSE ○ BETTER ○
RATE THE SEVERITY OF YOUR PROBLEM FROM 1-10 10

Review of Systems
DO YOU CURRENTLY HAVE ANY PROBLEMS LISTED BELOW: (PLEASE CHECK ONE)

Constitutional Symptoms
WEIGHT LOSS Y ○ N ○
FEVER Y ○ N ○
CHILLS Y ○ N ○
OTHER

Eyes
BLURRED VISION Y ○ N ○
EYE PAIN Y ○ N ○
OTHER

Cardiovascular
CHEST PAIN Y ○ N ○
RAPID HEARTBEAT Y ○ N ○
OTHER

Respiratory
SHORTNESS OF BREATH Y ○ N ○
FREQUENT COUGH Y ○ N ○
OTHER

Gastrointestinal
CONSTIPATION Y ○ N ○
DIARRHEA Y ○ N ○
ABDOMINAL PAIN Y ○ N ○
VOMITING Y ○ N ○
OTHER

Genitourinary
BLOOD IN URINE Y ○ N ○
URINARY FREQUENCY Y ○ N ○
BURNING ON URINATION Y ○ N ○
URINARY LEAKAGE Y ○ N ○
BEDWETTING Y ○ N ○
DIFFICULTY WITH INTERCOURSE Y ○ N ○
URINARY URGENCY Y ○ N ○
OTHER

Neurological
TREMORS Y ○ N ○
LOSS OF BALANCE Y ○ N ○
MEMORY LOSS Y ○ N ○
OTHER

Musculoskeletal
JOINT PAIN Y ○ N ○
BONE PAIN Y ○ N ○
BACK PAIN Y ○ N ○
OTHER

Endocrine
HEAT INTOLERANCE Y ○ N ○
COLD INTOLERANCE Y ○ N ○
INCREASED THIRST Y ○ N ○
OTHER

Hematologic
EASILY BRUISED Y ○ N ○
SWOLLEN LYMPH NODES Y ○ N ○
EASY BLEEDING Y ○ N ○
OTHER

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Patient Name Date

Urinary Symptom Index Questionnaire

(Check the box by the number that best applies to you for each question)

	Not at all	Less than 1 time in 5	Less than 1/2 the time	About 1/2 the time	More than 1/2 the time	Almost Always
1. Over the last month or so, how often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. During the last month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. During the last month or so, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. During the last month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. During the last month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. During the last month or so, how often have you had to push to begin urination?	0	1	2	3	4	5

	None	1 time	2 times	3 times	4 times	5 or more
7. During the last 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

Add up all numbers circled above and write the total in the space to the right.
SYMPTOM SCORE = 1 - 7 = Mild 8 - 19 = Moderate 20 - 35 Severe **YOUR TOTAL**

Quality of Life

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Thank you for completing this form. Please save it to your desktop after completion.
Then email it as an attachment to forms@urologicalassoc.com

Please open the attachment before emailing it to us to make sure the form saved properly to your computer with the completed information. If you cannot accomplish these steps please simply print the form and drop it off or mail it to us at 1644 Medical Center Point #200, Colorado Springs, CO 80907, or fax it to: (719) 622-6016 If your attachment is blank you may not have Adobe Reader installed on your computer. If that happens, or if you have any questions please call us at 719-219-3172.