Saint Luke's

Advanced Urologic Associates • 816-251-5100
Independence • 19001 E. 48th St. South, Independence, MO 64055
Lee's Summit • 110 NE Saint Luke's Blvd., Suite 255, Lee's Summit, MO 64086
Overland Park • 12330 Metcalf Ave., Suite 100, Overland Park, KS 66213

Dear: _____

Thank you for choosing the office of Dr's Wilson, Stanley, Lewing, Moore, McIntosh, Miller, Piontek, and DeRoo. We would like to make your visit with us as comfortable as possible.

Your appointment is scheduled:

_____ _____ at: _____ with _____
Day Date Time Doctor

We will make every effort to notify you as soon as possible if a medical emergency demands we change your appointment. Please notify our office as far in advance as possible if you will be unable to keep your appointment so that we may give your appointment time to another patient.

At the time of your appointment, please bring the following information to make your first visit more productive:

1. **Your insurance cards and/or Medicare card and a Picture ID**. If your insurance requires a written referral from your primary care doctor, please bring it with you. If your insurance requires a numbered "telephone" referral, please verify with your primary physician that this has been called in and when available, bring that number with you. You must present a picture ID to be seen.
2. **Copies of your medical records to date, including any recent x-rays or lab results**. If you are seeing our doctor to review x-rays or CT's that were previously taken you must bring the actual films or CD's with you.
3. **A current list of medications you are taking and their dosages**. This is very important to assist us in prescribing additional medication. We will periodically ask you to update this information.
4. **This packet of information completed** and ready to give to our office personnel.
5. **Required Co-Pays for your insurance**. We do not bill co-pays. They are due at the time of service.

We have enclosed a copy of our Patient Privacy Summary Notice. A complete Privacy Notice is available for your review.

New Patients must arrive 30 minutes prior to your doctor appointment so that we may complete the registration process. Late arrivals may have to be rescheduled.

If you have any questions, please give us a call at 816-251-5100.

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Advanced Urologic Associates – Intake Form

Today's Date: _____ Date of birth: _____
Name: _____ Primary Physician: _____
Local Pharmacy and Location: _____
Mail Order Pharmacy: _____
Reason for Visit: _____

Medications: Please include dosage and how many times a day. If you have an up to date copy we can copy it on the day of your appointment.

1. _____ 8. _____
2. _____ 9. _____
3. _____ 10. _____
4. _____ 11. _____
5. _____ 12. _____
6. _____ 13. _____
7. _____ 14. _____

Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____

Personal Medical History: Please check all that apply.

Arthritis ___	Elevated PSA ___	Hypertension ___	Prostate Cancer ___
Bladder Cancer ___	Prostatitis ___	Breast Cancer ___	Epididymitis ___
Enlarged Prostate __	Kidney Disease ___	Kidney Stones ___	Renal Cancer ___
Heart Disease ___	Diabetes ___	STD ___	Interstitial Cystitis ___
Erectile Dysfunction ___	GERD ___	Hormone Problems ___	Testicular Cancer ___
UTI ___	Urinary Incont. ___	HIV ___	Taking blood thinners___

Surgical History: Please list dates if known.

Appendectomy ___	Bladder Sling ___	Cholecystectomy ___	Colon Surgery ___
Hernia Repair ___	Kidney Removal ___	Kidney Stone Surgery ___	Lithotripsy ___
Prostate Surgery ___	Kidney Transplant ___	Tonsillectomy ___	Incontinence Surgery ___
Orthopedic Surgery ___	Heart Valve Surgery ___	Heart Surgery ___	

Family History: Please Indicate whom below.
M – Mother, F – Father, B – Brother, S – Sister, MGM – Maternal Grandmother, MGF – Maternal Grandfather, PGM – Paternal Grandmother, PGF – Paternal Grandfather

Kidney Stones _____	Diabetes _____	Thyroid Disease _____
Heart Disease _____	Prostate Cancer _____	Stroke _____
Kidney Cancer _____	Lung Problems _____	Bladder Cancer _____

Any other Conditions: _____

Social History: Circle Y (Yes) or N (No) and answer questions completely.
Drink Caffeine? # Servings per day _____ Coffee ___, Tea ___, Soda ___, Energy Drinks ___
Do You Smoke? Y or N Cigarettes ___, Cigars ___, Pipe ___. # per day ____ , # of year's ____
Ever Smoked? Y or N Year Quit: _____Do you Chew Tobacco? Y or N
Drink Alcohol? Y or N Amount? _____ Daily? Y or N Weekly? Y or N Occasionally? Y or N
Do you use Illicit drugs? Y or N Type: _____

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AUA SYMPTOM SCORE

Patient Name: _____ Today's Date: _____

(Circle One Number on Each Line)	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
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past 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
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, 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
Over the past month, how many times per night 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 the score for each number above and write the total in the space to the right. TOTAL: ____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

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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

Have you tried medications to help your symptoms? (Circle one) YES / NO

Did these medications help your symptoms? (Circle number)

1	2	3	4	5	6	7	8	9	10

No Relief(1) Complete Relief (10)

Male Patients Only:
Would you be interested in learning about a minimally invasive option that would allow you to discontinue your BPH (benign prostatic hypertrophy) medications? (Circle One) YES / NO

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Review of Systems

Please Circle any symptoms you have experienced in the last 30 days.

Constitution:
Fever
Chills
Weight Loss
Mailaise/Fatigue
Diaphoresis

Skin:
Rash
Itching

HEENT:
Hearing Loss
Tinnitus
Ear Pain
Ear discharge
Nosebleeds
Congestion
Sinus Pain
Stridor
Sore Throat

Musculoskeletal:
Myalgia
Neck Pain
Back Pain
Joint Pain
Falls

Eyes:
Blurred Vision
Double Vision
Photophobia
Eye Pain
Eye Discharge
Eye Redness

Cardiovascular:
Chest Pain
Palpitations
Orthopnea
Claudication
Leg Swelling
PND
Elevated B/P

Respiratory:
Cough
Hemoptysis
Sputum Prod.
SOB
Wheezing

GI:
Heartburn
Nausea
Vomiting
Abdominal Pain
Diarrhea
Constipation
Blood in Stools
Melena

Urinary:
Urgency
Frequency
Hematuria
Flank Pain
Urinating at Night
Loss of Urine Control
Slow Stream
Urinary Tract Infections
Bladder Pain
Kidney Stones
Difficulty with Erections
Vaginal Discharge
Estrogen Supplement
Hesitancy

Endo/Heme/Aller
Easy Bruise/Bleed
Environ. Allergies
Polydipsia

Neurological:
Dizziness
Headache
Tingling
Tremors
Sensory Change
Speech Change
Focal Weakness
Weakness
Seizures
LOC

Psychiatric:
Depression
Suicidal Ideas
Substance Abuse
Hallucinations
Nervous/Anxious
Insomnia
Memory Loss