potomac UROLOGY
2296 Opitz Blvd., Suite 350
Woodbridge, VA 22191

www.potomacurology.com
Tel: 703-680-2111
Fax: 703-878-3939

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1800 N. Beauregard St., Suite 300
Alexandria, VA 22311

Alok Desai, M.D. Pratik Desai, M.D. Nilay Gandhi, M.D. John Klein M.D. Inderjit Singh M.D.

NEW FEMALE PATIENT REGISTRATION FORM

Patient Name: _____ (Last) _____ (First) _____ (MI) ***DOB:*** ____/____/____

SSN: ____-____-____

Home Address: _____ (Street Address) _____ (Apt #) _____ (City) _____ (State) _____ (Zip Code)

Home Phone: (____) ____-____ ***Cell Phone***: (____) ____-____ ***Work Phone***: (____) ____-____

Primary Care Physician: _____ ***Sex***: _____ ***Marital Status***: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Language: ☐ English ☐ Other _____ ***Email***: _____

Patient's Employer/School: _____ _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Emergency Contact: _____ (Name) _____ (Relationship) Phone: (____) ____-____

Pharmacy: _____ (Name) _____ (Street Address) _____ (City) _____ (State) Phone: (____) ____-____

Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Island ☐ Black/African American ☐ White ☐ Hispanic ☐ Other _____

Primary Insurance: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber DOB: ____/____/____

Social Security Number: ____ - ____ - ____ Relationship to patient: _____

Subscriber's Employer: _____ Phone: (____) ____-____

Subscriber's Address: _____ (Street Address) _____ (Apt #) _____ (City) _____ (State) _____ (Zip Code)

Secondary Insurance: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber DOB: ____/____/____

Social Security Number: ____ - ____ - ____ Relationship to patient: _____

Subscriber's Employer: _____ Phone: (____) ____-____

Subscriber's Address: _____ (Street Address) _____ (Apt #) _____ (City) _____ (State) _____ (Zip Code)

How did you hear about us?

☐ Facebook
☐ Google
☐ Hospital follow-up
☐ Insurance company
☐ Primary Care doctor _____
☐ Referring physician _____
☐ Website
☐ Word of mouth
☐ Yelp
☐ OTHER: _____

_____ **Patient/Parent Signature** _____ **Printed Name** ____/____/____ **DOB** ____/____/____ **Date**

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Patient Name: _____

Why are you here today: _____

MEDICATIONS:

Please list any prescription medications, over-the-counter medications, and vitamin supplements you take routinely:

Are you taking **Aspirin**, **Plavix**, or any other form of **Blood Thinners**? ☐ Yes ☐ No

Please list Drug Allergies: _____

Medication	Strength/Dose	# of times per day taken

Use the additional MEDICATION page (page 5) if you need more space

MEDICAL HISTORY:

Please CHECK any of the following conditions which YOU have had or currently have:

☐ Anemia	☐ CHF (heart failure)	☐ Heart attack (MI)	☐ Low Testosterone	☐ Seizures
☐ Arthritis	☐ COPD	☐ Hepatitis C	☐ Mitral valve prolapse	☐ Thyroid disease
☐ Asthma	☐ CAD (heart disease)	☐ High blood pressure (HTN)	☐ MRSA infection	☐ Tuberculosis
☐ BPH	☐ CVA (stroke)	☐ High cholesterol	☐ Multiple sclerosis	☐ Vascular disease
☐ Cancer:	☐ Depression	☐ Inflammatory Bowel (IBD)	☐ Osteoporosis	Other:
Type _____	☐ Diabetes	☐ Irritable Bowel (IBS)	☐ Parkinson's disease	_____
☐ Chest pain	☐ GERD/Acid reflux	☐ Kidney stones	☐ Positive PPD	_____
☐ Chronic UTI's	☐ Gout (high uric acid)	☐ Liver disease	☐ Spinal cord injury	_____

SURGICAL HISTORY:

Please CHECK any procedures YOU have had and the date of the procedure:

	YEAR		YEAR	**FEMALES ONLY**	YEAR
☐ Adrenalectomy		☐ Hernia repair		☐ Bladder suspension	
☐ Appendectomy		☐ Hip replacement		☐ Breast biopsy	
☐ Back Surgery		☐ Knee replacement		☐ C-section	
☐ Bladder augment		☐ Laparoscopy		☐ Abdominal hysterectomy	
☐ Bladder removal		☐ Lithotripsy		☐ Mastectomy	
☐ CABG		☐ Liver biopsy		☐ Vaginal sling	
☐ Colectomy		☐ Kidney removal		☐ TAH/BSO	
☐ Colon surgery		☐ Pacemaker		☐ Tubal ligation	
☐ Cystoscopy		☐ Perc stone removal		☐ Vaginal hysterectomy	
☐ ESWL		☐ Kidney stone removal			
☐ Gall bladder		☐ Ureteral stent		☐ Last Menstrual Cycle	
☐ Gastric bypass		**OTHER:**		☐ Last PAP smear	
☐ Heart stent					

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Patient Name: _____

FAMILY HISTORY:

	Alive?	Age	Bladder cancer	Kidney cancer	Prostate cancer	Kidney stones	Diabetes	Stroke
Father								
Mother								
Brother								
Sister								
Uncle/Aunt								
Grandparents								

SOCIAL HISTORY:

Smoking: ☐ Current smoker (Packs/day: ____ , # years: ____) ☐ Former smoker (Year quit _____) ☐ Non-smoker

Recreational drug use: ☐ No ☐ Yes (_____) Exercise: ☐ No ☐ Yes (_____)

Caffeine: ☐ No ☐ Yes (_____) Alcohol: ☐ No ☐ Yes (_____)

Sexually active: ☐ No ☐ Yes Occupation: _____

REVIEW OF SYSTEMS:

Do you have any problems NOW related to the following systems? Please CHECK YES or NO.

Constitutional Symptoms
Fever ☐ Yes ☐ No
Chills ☐ Yes ☐ No
Headache ☐ Yes ☐ No
Weight gain/loss ☐ Yes ☐ No

Cardiovascular
Chest pain ☐ Yes ☐ No
Varicose veins ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Low blood pressure ☐ Yes ☐ No

Respiratory
Wheezing ☐ Yes ☐ No
Frequent cough ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No

Endocrine
Excessive thirst ☐ Yes ☐ No
Too hot/cold ☐ Yes ☐ No
Tired/sluggish ☐ Yes ☐ No
Other: _____

Ear/Nose/Throat/Mouth
Ear infection ☐ Yes ☐ No
Sore throat ☐ Yes ☐ No
Sinus problems ☐ Yes ☐ No
Other: _____

Gynecologic
Heavy periods ☐ Yes ☐ No
Irregular periods ☐ Yes ☐ No
Menopause ☐ Yes ☐ No
Hormone therapy ☐ Yes ☐ No

Integumentary
Skin rash ☐ Yes ☐ No
Boils ☐ Yes ☐ No
Persistent rash ☐ Yes ☐ No
Other: _____

Sexual History
Sexually active ☐ Yes ☐ No
Pain w intercourse ☐ Yes ☐ No
Leaking urine with intercourse ☐ Yes ☐ No

Neurologic
Tremors ☐ Yes ☐ No
Dizzy spells ☐ Yes ☐ No
Numbness ☐ Yes ☐ No
Headache ☐ Yes ☐ No

Gastrointestinal
Abdominal pain ☐ Yes ☐ No
Nausea/vomiting ☐ Yes ☐ No
Indigestion ☐ Yes ☐ No
Heartburn ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
IBS ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Rectal bleed ☐ Yes ☐ No
Other: _____

Hematologic/Lymphatic
Swollen glands ☐ Yes ☐ No
Blood clotting problem ☐ Yes ☐ No
Pulm embolism ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Other: _____

Eyes
Blurred vision ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No
Double vision ☐ Yes ☐ No
Other: _____

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Patient Name: _____

BLADDER SATISFACTION SURVEY

Which symptoms best describe you?

- ☐ Frequent urination (day, night, both)
- ☐ Sudden/strong urge to urinate
- ☐ Leaking with urge or no warning (unable to make it to the bathroom in time)
- ☐ Bowel leakage or constipation
- ☐ Leaking with sneezing/coughing/exercise
- ☐ Unable to empty the bladder completely
- ☐ Frequent urinary tract infections (UTI)
- ☐ None of these describe my symptoms

How long have you had these symptoms? _____ months OR _____ years

Have you tried medications to help your symptoms? ☐ YES ☐ NO

If YES, please CHECK all the medications you have tried:

☐ Detrol LA	☐ Ditropan XL	☐ Flomax	☐ Cardura
☐ Oxytrol patch	☐ Enablex	☐ VESIcare	☐ DDAVP
☐ Sanctura	☐ Elavil	☐ Elmiron	☐ Myrbetriq

☐ Other: _____

Did these medications help your symptoms?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
None					50%					Cured

Why did you stop medications if you did? ☐ Not working ☐ Expensive ☐ Side Effects

Describe medication side effects if you had any: _____

Behavioral modifications tried: _____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
None					50%					Very

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Patient Name: _____

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