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

www.potomacurology.com
Tel: 703-680-2111
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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 MALE PATIENT REGISTRATION FORM

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

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

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

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			MALES ONLY	YEAR
☐ Adrenalectomy		☐ Hernia repair				☐ Brachytherapy	
☐ Appendectomy		☐ Hip replacement				☐ Circumcision	
☐ Back Surgery		☐ Knee replacement				☐ Hernia repair	
☐ Bladder augment		☐ Laparoscopy				☐ Hydrocelectomy	
☐ Bladder removal		☐ Lithotripsy				☐ Laser of prostate	
☐ CABG		☐ Liver biopsy				☐ Orchiectomy	
☐ Colectomy		☐ Kidney removal				☐ Penile prosthesis	
☐ Colon surgery		☐ Pacemaker				☐ Prostate biopsy	
☐ Cystoscopy		☐ Perc stone removal				☐ Prostatectomy	
☐ ESWL		☐ Kidney stone removal				☐ Spermatocelectomy	
☐ Gall bladder		☐ Ureteral stent				☐ TURP	
☐ Gastric bypass		OTHER:				☐ Varicocele ligation	
☐ Heart stent						☐ Vasectomy	

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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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INTERNATIONAL PROSTATE SYMPTOM SCORE (IPSS) ***MALE PATIENTS ONLY***

Over the past MONTH, how often have you....	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
1. ...had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. ...had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. ...found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. ...found it difficult to postpone urination?	0	1	2	3	4	5
5. ...had a weak urinary stream?	0	1	2	3	4	5
6. ...had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5 times or more
7. 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

TOTAL SCORE = _____

QUALITY OF LIFE (QOL)	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

INTERNATIONAL INDEX OF ERECTILE FUNCTION (IIEF) ***MALE PATIENTS ONLY***

Over the past 6 MONTHS, ...	Very Low	Low	Moderate	High	Very High
1. ...how do you rate your confidence that you could get and keep an erection?	1	2	3	4	5
	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
2. ...when you had erections with sexual stimulation, how often were your erections hard enough for penetration?	1	2	3	4	5
3. ...during sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	1	2	3	4	5
	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
4. ...during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	1	2	3	4	5
	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
5. ...when you attempted sexual intercourse, how often was it satisfactory for you?	1	2	3	4	5

TOTAL SCORE = _____

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