Today's Date: _____

BRAD A. WOLFSON, M.D.
LAS PALMAS MEDICAL PLAZA
555 East Tachevah Drive 2W, 101
Palm Springs, CA 92262
(760) 320-6005

Kindly complete all forms in their entirety, as they will assist us in your overall healthcare.
Please do not hesitate to ask for assistance. THANK YOU!

PATIENT PERSONAL INFORMATION:

Last Name:	First Name:	Middle:
Social Security:	Birth date:	
Drivers Lic#:	Sex: ☐ M or F ☐	Spouse's Name:
Preferred Language*:	Race*:	Ethnicity*:
Occupation:	Employer:	
Primary Care Physician or Internist:		Office Phone #:
Whom may we thank for referring you this office?		
Pharmacy of Choice:	City:	Phone #:

PATIENT MAILING ADDRESS	PHONE NUMBER	Is it okay to leave a message?
Street:	Home Phone #:	☐ Yes or No ☐
City, State, Zip	Cell Phone #:	☐ Yes or No ☐
Email Address:	Work Phone #:	☐ Yes or No ☐

INSURANCE INFORMATION (Please present your insurance cards to the front desk to be copied)

Primary Insurance:	Group #:	Policy #:
Policy Holder's Name:	Birth date:	Policy Holder's Social Security:
Employer:	Patient's Relationship to Policy Holder:	
Secondary Insurance (if applicable):	Group #:	Policy #:
Policy Holder's Name:	Birth date:	Policy Holders Social Security:
Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other		

IN CASE OF EMERGENCY

Emergency Contact:	Phone #:	Relationship to Patient:

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I hereby authorize Brad A. Wolfson, M.D. to release any information required to process my claims. I authorize the use of this signature on all my insurance submissions.

_____ _____ _____

Signature of Responsible Party Relationship Date

* The Federal Government requires Brad A. Wolfson, M.D. to gather certain demographic information.

Patient Last Name:	First:	Middle:	Date of Birth:

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

REASON FOR VISIT TODAY (Please describe your problem/reason in detail):

Please list relevant symptoms:

1.) _____ 2.) _____ 3.) _____

4.) _____ 5.) _____ 6.) _____

Have you seen a Urologist before? Yes□ No□ If yes, please list doctor _____

What blood tests or X-rays have you had?

_____

What treatment(s) have you had?

_____

Please check all boxes, if any of these conditions have occurred, past or present.

Yes□ No□ Blood in Urine
Yes□ No□ Painful Urination
Yes□ No□ Kidney Stones
Yes□ No□ Infections in Bladder if Kidney
Yes□ No□ History of Urologic Surgery
Yes□ No□ Family History of Prostate Cancer
Yes□ No□ Incontinence of Urine or wetting accidents
Yes□ No□ Erectile Dysfunction
Yes□ No□ Difficulty in Urination, weak stream
Yes□ No□ Need to urinate NOW (urgency)
Yes□ No□ Neurologic condition which affects your bladder (stroke, back/disc problem)

PATIENT CURRENT OR PAST MEDICAL HISTORY: (Please check any medical conditions)

□ Heart Disease	□ Heart Attack	□ Stroke
□ Diabetes On Insulin? □ Yes □ No	□ Cancer (Please specify type)	□ Hypertension (High Blood Pressure)
□ High Cholesterol	□ Prostate Cancer	□ Depression
□ Kidney Stones	□ Kidney Disease	□ Dialysis
□ HIV/AIDS	□ Parkinson's	□ Alzheimer's
□ Hepatitis A / B / C	□ Liver Disease	□ Epilepsy or Seizures
□ Other:		

Patient Last Name:	First:	Middle:	Date of Birth:

PATIENT SURGICAL HISTORY: **(Please list any surgeries you have had and the year they were performed)**

Name of Surgery	Date of Surgery (Year)

FAMILY MEDICAL HISTORY: **(Please list any medical conditions in your family and specify which family member)**

CONDITION	FAMILY MEMBER (mother, father, etc)	CONDITION	FAMILY MEMBER (mother, father, etc)
☐ Heart Disease		☐ Prostate Cancer	
☐ Diabetes		☐ Cancer Type:	
☐ Stroke		☐ High Cholesterol	
☐ Alzheimer's		☐ Parkinson's	
☐ Heart Attack		☐ Kidney Disease	
☐ High Blood Pressure		☐ Dementia	
☐ Other:			

Are you diabetic: ☐ **Yes** ☐ **No**

Are you allergic to Iodine or Shellfish?: ☐ **Yes** ☐ **No**

Are you allergic to any medications? ☐ **YES** ☐ **No** If yes, please list _____

Current WT:_____lbs.

HABITS:

Have you ever smoked or used tobacco products? ☐ **Yes** ☐ **No**

If yes, how many packs per day? _____

Do you smoke now? ☐ **Yes** ☐ **No** If no, when did you quit? _____

Do you drink alcoholic beverages? ☐ **Yes** ☐ **No** If yes, how often? _____

How many drinks per day? _____

Do you drink caffeine (coffee, soda, etc.)? ☐ **Yes** ☐ **No**

If yes, How many drinks per day? _____

FEMALE PREGNANCY HISTORY:

When was your last menstrual period? _____ **Are you presently pregnant?** _____

How many times have you been pregnant? _____

Number of Vaginal Deliveries _____ **Number of Caesarians** _____

Patient Last Name:	First:	Middle:	Date of Birth:

REVIEW OF SYSTEMS

(Please answer all questions to the best of your knowledge)

Have you had any of the following problems recently?

GENERAL:

☐ Weight loss or gain	☐ Fatigue	☐ Sleep Apnea
☐ Fever or chills	☐ Headaches	☐ Sexually Transmitted Disease

EARS / EYES / NOSE / THROAT:

☐ Sinus problems	☐ Glaucoma	☐ Cataracts
☐ Blurry or double vision	☐ Hearing loss	

CARDIOVASCULAR:

☐ Chest pain or angina	☐ Heart murmur	☐ Heart attack
☐ Heart surgery	☐ Irregular heat beat	☐ Ankle, feet, hand swelling
☐ Vascular disease	☐ Shortness of breath	☐ Hypertension (High Blood Pressure)

RESPIRATORY:

☐ Chronic/frequent cough	☐ Coughing up blood	☐ History of tuberculosis
☐ Pneumonia	☐ Asthma	☐ Emphysema

GASTROINTESTINAL:

☐ Hepatitis or jaundice	☐ Bowel disease	☐ Hemorrhoids
☐ Rectal Bleeding	☐ Diarrhea	☐ Constipation

HEMATOLOGIC / LYMPHATIC:

☐ Swollen glands	☐ Bruise easily	☐ Use a blood thinner like
☐ History of Anemia	☐ HIV	☐ Coumadin or Plavix

METABOLIC AND ENDOCRINE:

☐ Diabetes	☐ Use of steroids	☐ Use of prednisone
☐ Thyroid problems	☐ Excessive thirst	☐ Tired/ sluggish
☐ Too hot/cold		

MUSCULOSKELETAL:

☐ Fractures	☐ Arthritis	☐ Back Pain

NEUROLOGICAL:

☐ Loss of consciousness	☐ Seizures	
☐ Paralysis	☐ Dizziness or Fainting	☐ Tremors
☐ Frequent/ Severe Headaches		

PSYCHOLOGIC:

☐ Depression	☐ Anxiety	☐ Sleep Disorder
☐ Hallucinations	☐ Suicidal thoughts	

SKIN:

☐ Skin Cancer	☐ Rash
☐ Other skin disease _____	

Please rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physician's signature: _____ Date: _____

Nurse Only: Pulse: _____ Temperature: _____ Blood Pressure: _____

Brad A. Wolfson, M.D., Adult and Pediatric Urology

MEDICATION LIST

DATE: 08-09-2018

NAME: ____________________ PHONE: ______________ BIRTHDATE: ____________

PHARMACY: ______________________ PHARMACY PHONE: ____________________

MEDICATION ALLERGIES: ____

MEDICATION	STRENGTH	HOW OFTEN?	REASON

** REMEMBER TO UPDATE YOUR MEDICATIONS **

- Mark out medications that are discontinued.
- Add new medications that are started.

INTERNATIONAL PROSTATE SYMPTOM SCORE SHEET (I-PSS)

Patient Name _____ Date of Birth _____ Today's Date 08-09-2018

IN THE PAST MONTH:	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 How often have you had a sensation of not emptying your bladder completely when urinating?	0	1	2	3	4	5	
2. FREQUENCY How often have you had to urinate less than 2 hours after you finish urinating?	0	1	2	3	4	5	
3. INTERMITTENCY How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. URGE TO URINATE How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. WEAK STREAM How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. STRAINING How often have you had to push or strain to start urination?	0	1	2	3	4	5	
	NONE	1 TIME	2 TIMES	3 TIMES	4 TIMES	5 TIMES	
7. URINATING AT NIGHT: How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
TOTAL I-PSS SCORE:							

Scoring: 1-7: Mild 8-19: Moderate 20-35: Severe

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
BOTHERSOME OF URINARY SYMPTOM: 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

The International Prostate Symptom Score (I-PSS) is based on the answers on the 7 questions concerning urinary symptoms and 1 question concerning the effect of symptoms. Each question concerning urinary symptoms allows the patient to choose 1 of 6 answers indicating severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptotic to very symptomatic.

The first 7 questions of the I-PSS are identical to the questions appearing on the American Urological Association (AUA) symptom Index, which currently categorizes symptoms as follows: Mld- (symptoms score less than or equal to 7), Moderate-(symptom score range 8-19), Severe- (symptom score range 20-35.)

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), recommends the use of the additional questions to begin a discussion with patients about the effect of the symptoms on their lives. The answers to this question range from "delighted" to "terrible" or 0 to 6.