THOMAS UROLOGY CLINIC
PATIENT REGISTRATION

Patient Name: (Last)_____(First) _____ Middle Initial_____

Address: _____ City, State, Zip: _____

Marital Status: Single Married Widowed Divorced

DOB: _____/_____/_____ SSN: _____ ☐ Male ☐ Female

Primary Phone: _____ Alt Phone:_____

Email(Used for invitation to Patient Portal & notification of appointments): _____

Primary Doctor: _____ Referring Doctor: _____

RESPONSIBLE PARTY(If patient is not responsible for bill payment, please indicate who is responsible)

Name: (Last) _____ (First) _____ (MI) _____ DOB: _____

Phone: (__)_____ Address: _____

City, State, Zip: _____ Relationship to Patient: _____

PRIMARY INSURANCE: _____ ID: _____

Policy Holder Name: (Last) _____ (First) _____ (MI) _____

DOB: _____ Relationship to Patient _____

SECONDARY INSURANCE _____ ID: _____

Policy Holder Name: (Last) _____ (First) _____ (MI) _____

DOB: _____ Relationship to Patient _____

EMERGENCY CONTACT

Name: (Last) _____ (First) _____

Phone: _____Relationship to Patient: _____

PREFERRED PHARMACY: _____Address: _____

AUTHORIZATION FOR PERSONS TO WHOM MY MEDICAL INFORMATION MAY BE DISCLOSED:

_____	_____	_____
Person's Name/Organization	Relationship to Patient	Contact info
_____	_____	_____
Person's Name/Organization	Relationship to Patient	Contact info

Patient signature:_____ **Date:**_____

THOMAS UROLOGY CLINIC

KENNETH R. THOMAS, MD
MICHELLE BEASLEY, FNP-C
109 DOCTORS PARK
STARKVILLE, MS 39759
PHONE: 662.498.1400
FAX: 662.498.1407

CONSENT TO TREAT

I hereby authorize Kenneth Thomas, MD to administer treatment and medications as may be deemed medically necessary and advisable.

AUTHORIZE TO RELEASE INFORMATION & ASSIGNEMENT OF BENEFITS

I hereby authorize Kenneth Thomas, MD or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare), Insurance companies or third parties, any information needed to determine these benefits payable for the related services.

I request that authorized Medicare or Insurance payments of medical benefits be made to Kenneth Thomas, MD.

FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Kenneth Thomas, MD, Thomas Urology Clinic and if this assignment is rejected, modified or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. I also understand and agree that all deductibles, coinsurance, non-covered charges and other items not paid by insurance, health plan or other third party payers are due and payable at time of service. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel and court.

This authorization and assignment may be revoked by me at any time by written notice.
I agree that a photocopy of this form may be used in lieu of the original.

CLINIC PROVIDER POLICY

Thomas Urology Clinic has multiple providers on staff, including Nurse Practitioners. Due to patient volume, we cannot guarantee that you will be seen by any particular provider. Our providers collaborate to give you the best possible care. By signing below, you acknowledge this clinic policy.

RECIEPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of Thomas Urology Clinic's Notice of Privacy Practices.

_____
Patient Signature

_____ _____
Patient Name (printed) Date

THOMAS UROLOGY CLINIC

Dr. Kenneth Thomas
Michelle Beasley, FNP-C
109 Doctors Park
Starkville, MS 39759

MALE MEDICAL HISTORY FORM

Name: _____ DOB: _____
Family Physician or Referring Physician: _____

This questionnaire is very important! These questions are designed to aid your doctor in assessing your problem, so please try to answer each question concisely and accurately. All information in this report and in this office is kept in the strictest confidence.

CHIEF COMPLAINT: What is the main reason for your visit today? Be precise.

_____

_____

Do you have **Urinary Symptoms**? If so, please fill out this section. If not, skip to the next section.

	Yes	No
1.) Do you leak urine? If YES, how many pads do you use per day? _____	☐	☐
2.) Does it burn or sting when you urinate?	☐	☐
3.) How often do you urinate during the day? (every 30 minutes, every 2 hours etc.) _____		
4.) Do you get the urge to urinate so badly that you do not think you will get to the bathroom in time?	☐	☐
6.) Have you ever had an infection in your urinary tract? (kidneys, bladder, prostate)	☐	☐
7.) Is there pain in the : a.) Lower abdomen (bladder)? b.) Groin? c.) Testicles? d.) Behind the scrotum or testicles?	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐

Do you think you have or have you ever had a **Kidney Stone**? If so, please fill out this section. If not, skip to the next section.

	Yes	No
1.) Do you have pain in the flank or kidney area? If YES, Left _____ or Right _____	☐	☐
2.) Have you ever had a kidney stone? If not, go to the next section. If YES a.) When? _____ b.) How many? _____	☐	☐

c.) Passed spontaneously? _____ d.) Removed surgically? _____ e.) Lithotripsy (shock waves)? _____		
What was stone made of? Calcium? _____ Uric acid? _____ Other? _____		
Was a metabolic evaluation done to determine the cause of the stone?	☐	☐
Were you placed on stone prevention therapy? What? _____	☐	☐

Are you here for **blood in your urine**? If so, please fill out this section. If not, skip to the next section.

	Yes	No
1.) Have you seen blood in you urine? (If no, go to question #3.)		
If YES a.) Was the blood only at the beginning of the stream?	☐	☐
b.) Throughout the stream?	☐	☐
c.) At the end of the stream?	☐	☐
Was the bloody urine (check all that apply)		
a.) Tea colored	☐	☐
b.) Rose wine/ cranberry colored	☐	☐
c.) Burgundy wine colored	☐	☐
d.) Clots	☐	☐
2.) Was there any pain or burning with the bloody urine?	☐	☐
3.) Has a doctor found blood in your urine under a microscope?	☐	☐

Review of Systems: (Please CHECK all the following symptoms you have recently had)

- ☐ Fever
- ☐ Chills
- ☐ Unintentional Weight Loss
- ☐ Sleeping Problems
- ☐ Fatigue
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Bloating
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Loss of Appetite
- ☐ Excessive thirst
- ☐ Excessive Sweating
- ☐ Increased/decreased energy level

Please list ANY other symptoms you currently have that are not listed above_____
_____

Social History

Do you use any tobacco products of any kind? ☐ Yes ☐ No
Approximately how much? _____
Do you consume alcohol? ☐ Yes ☐ No
How much? _____

Please list all surgeries and include dates (approximate):

Procedure/Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking **ANY** medications now? (This includes Prescriptions, over the counter, and herbal medications.)
□ Yes □ No
If yes, please list below:

Name of Medication	Dosage	How Often

Are you allergic to **ANY** medications? □ Yes □ No

Name of Medication	Type of Reaction

Medical History

Have you ever been diagnosed with the following problems?
Cancer: □ Yes □ No If yes, what kind?_____

Liver Disease	□ Yes □ No	Emphysema	□ Yes □ No
Asthma	□ Yes □ No	HIV	□ Yes □ No
Kidney Disease	□ Yes □ No	Seizures	□ Yes □ No
Anemia	□ Yes □ No	Reflux	□ Yes □ No
Stroke	□ Yes □ No	Ulcerative Colitis	□ Yes □ No
COPD	□ Yes □ No	Heart Attack	□ Yes □ No
Sleep Apnea	□ Yes □ No	Anxiety	□ Yes □ No
High Cholesterol	□ Yes □ No	Diabetes	□ Yes □ No
High Blood Pressure	□ Yes □ No	Hyperthyroidism (High)	□ Yes □ No
Heart Disease	□ Yes □ No	Congestive Heart Failure	□ Yes □ No
Blood Clots	□ Yes □ No	Depression	□ Yes □ No
Elevated PSA	□ Yes □ No	Arthritis	□ Yes □ No
Hepatitis	□ Yes □ No		

Other conditions not listed? _____

Family History

Please list any diseases that run in your family such as cancer, kidney stones, diabetes, etc.

DISEASE	FAMILY MEMBER
_____	_____
_____	_____
_____	_____
_____	_____

COMPLETE HEALTH Checklist For Men

Symptom (please check mark)	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining mental ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight gain/Belly fat/Inability to lose weight				
Breast development				
Shrinking testicles				
Rapid hair loss				
Decrease in beard growth				
New migraine headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or absent ejaculations				
No result from ED medications				
Family History	**Never**	**Mild**	**Moderate**	**Severe**
Heart disease				
Diabetes				
Osteoporosis				
Alzheimer's disease				

	0	*1*	*2*	*3*	*4*	*5*
	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.) Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?						
2.) Over the past month or so, how often have you had to urinate again less than two hours after they have finished urinating?						
3.) Over the past month or so, how often have you found that you stopped and started again several times when you urinated?						
4.) Over the past month or so, how often have you found it difficult to postpone urination?						
5.) Over the past month or so, how often have you had a weak urinary stream?						
6.) Over the past month or so, how often have you had to push or strain to begin urination?						
7.) Over 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 go up in the morning?						

8.) If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel?

(0) Delighted
(1) Pleased
(2) Mostly satisfied
(3) Mixed- equally satisfied and dissatisfied
(4) Mostly dissatisfied
(5) Unhappy
(6) Terrible

<u>TOTAL SYMPTOM SCORE</u>

SUM OF QUESTIONS 1 TO 8= _____

Are you interested in learning more about treatment alternatives to medications (Circle One)?

Yes **No** **Not Applicable**

SEXUAL HEALTH INVENTORY FOR MEN

*Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select **one** and **only one** response for **each question.***

1.) How do you rate your **confidence** that you could get and keep an erection?
- 1- Very low
- 2- Low
- 3- Moderate
- 4- High
- 5- Very high

2.) When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)?
- 0- No sexual activity
- 1- Almost never or never
- 2- A few times (much less than half the time)
- 3- Sometimes (about half the time)
- 4- Most times (much more than half the time)
- 5- Almost always or always

3.) During sexual intercourse, **how often** were you able to maintain your erection after you had penetrated (entered) your partner?
- 0- Did not attempt intercourse
- 1- Almost never or never
- 2- A few times (much less than half the time)
- 3- Sometimes (about half the time)
- 4- Most times (much more than half the time)
- 5- Almost always or always

4.) During sexual intercourse, **how difficult** was it to maintain your erection to completion of intercourse?
- 0- Did not attempt intercourse
- 1- Extremely difficult
- 2- Very difficult
- 3- Difficult
- 4- Slightly difficult
- 5- Not difficult

5.) When you attempted sexual intercourse, **how often** was it satisfactory for you?

Did not attempt intercourse
- 0- Almost never or never
- 1- A few times (much less than half the time)
- 2- Sometimes (about half the time)
- 3- Most times (much more than half the time)
- 4- Almost always or always

Add the numbers corresponding to questions 1-5. If your score is 21 or less, you may want to speak with your doctor.

TOTAL SCORE=_____