RUPP UROLOGY

631 SW Horne Suite 150
Topeka, KS 66606
(785) 354-RUPP (7877)

Patient Information

S.S.#	First Name & Mid. Initial	Last Name	Please Circle
			Mr. Mrs. Ms. Dr. Rev. Sr.

Street	City	State	Zip

Date of birth Age	Marital Status	Sex	Home Phone	Work Phone

Emergency Phone	Contact Name	Relationship	E-Mail Address (Patient)

Referring Physician	Address	Phone No.

Family Physician	Address	Phone No.

Employer	Address	Phone No.

Guarantor Information

Guarantor Name	Address	Phone No.

Employer & Address & Phone No.	S.S. #	Birthdate

Insurance Information

	Insurance Company	Policy No.	Group No.	Holder	Co-Pay
Primary					
Secondary					

Is this a Worker's Comp related injury? If yes, fill in the information below ☐ Yes ☐ No

Is this accident related? ☐ Yes ☐ No

Injury Date	Company	Address	Phone No.	Contact

Claim No. – If Worker's Comp	Describe Injury

Does Insurance require precertification prior to hospitalization ☐ Yes ☐ No

Does insurance require a second opinion ☐ Yes ☐ No

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Rupp Urology LLC. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges and non-covered services whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Signed_____ Date _____

Rupp Urology

631 SW Horne Street, Suite 150
Topeka, Kansas 66606

PLEASE ANSWER THE FOLLOWING 5 QUESTIONS:

1) **Patient Name**: _____

2) **DOB**: _____

3) **Preferred Language**: _____

4) **Race**:
(choose one)

____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ Native Hawaiian or Other Pacific Islander
____ White

5) **Ethnicity**:
(choose one)

____ Hispanic or Latino
____ Not Hispanic or Latino

The choices in these lists are determined by the U.S. Centers for Disease Control and Prevention (CDC).

Rupp Urology
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

1. I, _____, acknowledge receipt of Rupp Urology Notice of Privacy Practices.

_____ _____
Signature Date

2. With whom do you give us permission to discuss your medical or financial information? **If you choose not to name anyone, please indicate "NO ONE".**

_____ _____
Name Relationship

_____ _____
Name Relationship

3. May we contact you and leave messages, possibly containing medical information, appointment scheduling, billing information, etc. on your home and/or cell phone?

☐ Yes ☐ No

If yes, please provide phone numbers:

☐ Cell_____ ☐ Home_____

4. The above will remain in effect until revoked by me in writing.

_____ _____
Signature Print Name

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

RUPP UROLOGY CLINIC

Date:_____ Age:_____ NEW FEMALE PATIENT: _____

INS:_____ **PCP or Ref Dr:** _____ **D.O.B.** _____

Constitutional: Wt:_____ BP:_____ P: _____ Temp:_____ Gen App/Orientation:_____

Referred by/for: _____

Chief Complaint: _____

HPI/and/or DX: (Location, Quality, Timing, Context)_____

FOR PHYSICIAN ONLY BELOW THIS LINE

Ass/signs/symptoms: _____

Modifying Factors: _____ Duration:_____ Severity: _____

Past Surgical History: _____

Past Medical History: _____

Obstetric History: # pregn's _____ #vaginal deliveries _____ Hysterectomy ☐ Yes ☐ No

See patient History Form Dated: _____ ☐ No changes in History except as noted in HP1

PExam: WNL Abnormal WNL Abnormal

Neurological: Reflexes ☐ Sensory ☐ _____
Skin: Inspection ☐ Palpation ☐ _____
Lungs: Effort ☐ Auscultation ☐ _____
Abdomen: Liver/Spleen ☐ Bladder/Kidney ☐ _____

Psych: Mood/Affect ☐ Oriented x 3 ☐ _____
Neck: Symmentry ☐ Size ☐ _____
Cardio: Peripheral ☐ Auscultation ☐ _____
Lymphatics: Groin ☐ Neck ☐ _____

GU EXAM	NORMAL EXAM	POSITIVE FINDINGS
Abdomen	No masses ☐ No tenderness ☐ No organomegaly ☐	
External Genitalia	Appearance normal ☐ No lesions ☐	
Urethral meatus	Normal size ☐ No Prolapse ☐	
Urethra	No masses ☐ No tenderness ☐ No scarring ☐	
Bladder	No masses ☐ No tenderness ☐ No fullness ☐	
Cervix	Appearance normal ☐ No lesions ☐ No discharge ☐	
Uterus	WNL size/contour/position ☐ No tenderness ☐ No descent ☐	
Adnexa/parametria	No masses/tenderness ☐ No nodules ☐	
Anus/Perineum	Normal ☐ No hemorrhoids ☐ Hemoccult Not Indicated ☐	
Vagina	Appearance normal ☐ No discharge ☐ No lesions ☐	
	No Cystocele ☐ No Rectocele ☐ No Enterocele ☐	

UA: Color Sp. Grav PH: Leukocytes: Nitrite: Protein: Glucose:

Ketones: Urobilinogen: Bilirubin: Blood: **BladderVol:** _____ml Tech:

Cysto/Dil/other procedure:

X-Rays: _____ MDM: Straight d (1) ☐ (2) ☐ Low (3) ☐ Mod (4) ☐ High (5) ☐

Impression/DX:_____

Plan:_____

Return Visit:_____

Physician Signature:_____ **Letter Dictated to:** _____

System & Services of Kansas Inc. Topeka, KS Form No. 88-258327-2

RUPP UROLOGY CLINIC
FEMALE Patient History Form

Last Name:_____ First Name: _____ Date of Birth:_____ Date: _____

Your Primary Care Physician: _____Patient's Signature: _____

PERSONAL MEDICAL HISTORY

Medical (☐ None) Otherwise list all past serious illnesses and approximate date (Last 10 - 15 years)
(Examples: High blood pressure, Diabetes, Cancer, Heart Disease, Stroke, HIV, Migraines, Kidney Disease)

_____

_____

_____

Pregnancy History (if applicable)_____# of pregnancies_____# of vaginal deliveries_____Hysterectomy age

Surgery (☐ None) Otherwise, list type and approximate year. *(Examples: Heart, Appendectomy, Hysterectomy, Hernia)*

_____

_____

Current Prescription Medications (☐ None)

Name of drug Dose

1) _____
2) _____
3) _____
4) _____

If questions, please bring medication bottles with you

Name of drug Dose

5) _____
6) _____
7) _____
8) _____

Over the counter medicines. *(Ex: Aspirin, Tylenol, vitamins, herbals)* _____

Allergies (☐ None that I know of)

I AM ALLERGIC TO: *(If yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)*

☐ Latex ☐ Shellfish ☐ Iodine or X-ray dye ☐ Penicillin ☐ Sulfa Drugs ☐ Aspirin ☐ Antibiotics

Other/Explain _____

PAST FAMILY HISTORY OF DISEASE

Family History of:	Yes	No	Family Member		Yes	No	Family Member
1) Heart Disease	☐	☐	_____	6) Bladder Cancer	☐	☐	_____
2) Kidney Disease	☐	☐	_____	7) Kidney Cancer	☐	☐	_____
3) Kidney Stones	☐	☐	_____	8) Prostate Cancer	☐	☐	_____
4) Diabetes	☐	☐	_____	9) Stroke	☐	☐	_____
5) Bleeding Problems	☐	☐	_____	OTHER:			_____

(OVER)

_____

Brad W. Rupp, M.D.

SOCIAL HISTORY

Do you smoke?	Yes	No	More than 1 1/2 packs a day?	Yes	No
Do you drink alcohol?	Yes	No	More than 6 drinks a week?	Yes	No

How many glasses of water do you usually drink everyday? _____

How many cups of coffee/tea or caffeinated drinks do you usually drink every day? _____

Urology History:

Circle Yes or No

1) Burning with urination	Yes	No
2) Ever notice blood in urine	Yes	No
3) Urgency to urinate (feel like you have an urgent need to urinate)	Yes	No
4) Hesitancy starting to urinate	Yes	No
5) Unable to empty completely	Yes	No
6) Unable to urinate at all	Yes	No
7) Need to urinate frequently	Yes	No
8) Get up at night to urinate	Yes	No
How many times?_____		
9) Urine leakage (incontinence)	Yes	No
10) History of Kidney Stones	Yes	No
11) Felt lumps in genitalia	Yes	No

Comments:

_____

_____

REVIEW OF SYSTEMS

Constitutional Symptoms			Comments
Fever/Chills	Yes	No	
Bad Headaches	Yes	No	
Weight/appetite changes	Yes	No	
Other:_____			

Allergic/Immunologic		
Hay Fever	Yes	No
Drug Allergies	Yes	No
Other:_____		

Neurological		
Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness/tingling	Yes	No
Stroke	Yes	No
Other:_____		

Endrocrine		
Excessive Thrist	Yes	No
Too hot/too cold	Yes	No
Tired/sluggish	Yes	No
Other:_____		

Eyes		
Blurred Vision	Yes	No
Double Vision	Yes	No
Other:_____		

Gastrointestinal			Comments
Abdominal pain	Yes	No	
Nausea/vomiting	Yes	No	
Indigestion/heartburn	Yes	No	
Constipation/diarrhea	Yes	No	
Other: _____			

Psychologic		
Depression	Yes	No
Anxiety over condition	Yes	No
Other: _____		

Cardiovascular		
Chest Pain	Yes	No
Swelling in ankles	Yes	No
High blood pressure	Yes	No
Other: _____		

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

Musculoskeletal		
Joint pain	Yes	No
Neck pain	Yes	No
Back pain	Yes	No
Loss of strength	Yes	No
Other: _____		

Respiratory		
Wheezing	Yes	No
Frequent cough	Yes	No
Shortness of breath	Yes	No
Other: _____		

Hematologic/Lymphatic		
Swollen glands	Yes	No
Blood clotting problems	Yes	No
Excessive bruising	Yes	No
Other: _____		

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

Are you a Diabetic? ☐ Yes ☐ No