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? ☐ Yes ☐ No
If yes, fill in the information below

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:_____ PATIENT NAME:_____

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

Referred by/for: _____

Chief Complaint: _____

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

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

FOR PHYSICIAN ONLY BELOW THIS LINE

Ass/signs/symptoms: _____

Modifying Factors: _____ Duration:_____ Severity: _____

Past Surgical History: _____

Past Medical History: _____

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

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
Penis	Circumcised ☐ No lesions/masses ☐ Meatus normal ☐	
Testes	Normal size ☐ Desc'd bilater ☐ No masses/tenderness ☐	
Epididymis	Normal size ☐ No masses ☐ No tenderness ☐	
Scrotum	No lesions ☐ No rashes ☐ No Varicocele ☐ No ing hernia ☐	
Seminal Vesicles	Normal ☐	
Rectal	Normal Spincter tone ☐ No tenderness ☐ No masses ☐	
Anus/Perineum	Normal ☐ No hemorrhoids ☐ Hemoccult Not Indicated ☐	
Prostate	Normal Symmentry ☐ No nodules ☐ No tenderness ☐	

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

Ketones: Urobilinogen: Bilirubin: Blood: **BladderVol:** _____ ml Tech:

Cysto/Dil/other procedure: _____

X-Rays: _____

☐ PSA _____ ☐ F/T PSA _____ 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. 88-258327-1

RUPP UROLOGY CLINIC
MALE 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)

_____

_____

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

_____

_____

Current Prescription Medications (☐ None) ***If questions, please bring medication bottles with you***

Name of drug	Dose	Name of drug	Dose
1)		5)	
2)		6)	
3)		7)	
4)		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:			

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 every day? _____

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

(OVER)

_____

Brad W. Rupp, M.D.

Prostate Symptom Score

Please circle the answer that best represents your response to each of the following questions.

	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	Patient score
Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating.	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated.	0	1	2	3	4	5	
Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
Nocturia Over the past month, how many times did you 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+	
						Your Total Score	

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
Quality of Life due to Urinary Symptoms If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

REVIEW OF SYSTEMS

Constitutional Symptoms

Fever/Chills	Yes	No
Bad Headaches	Yes	No
Weight/appetite changes	Yes	No

Other: _____

Allergic/Immunilogic

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: _____

Endocrine

Excessive Thirst	Yes	No
Too hot/too cold	Yes	No
Tired/sluggish	Yes	No

Other: _____

Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No

Other: _____

Gastrointestinal

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
Persistant 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: _____

☐ Have you felt lumps in genitalia?

☐ Do you have a history of Kidney Stones?

Are you a Diabetic?

☐ Yes ☐ No