Rupp Urology Clinic
Bradley W. Rupp, M.D.
631 SW Horne Street, Suite 150 ~ Topeka, KS 66606
Telephone: (785) 354-7877 ~ General Fax: (785) 354-7878
Medical Information Electronic Fax: (785) 235-1008

## Patient Information

| Title | First Name | MI | Last Name | Social Security Number |
|---|---|---|---|---|
| __Dr. __Mr. __Mrs. __ Ms. | | | | |

| Home Address | City | State | Zip Code | Date of Birth | Gender |
|---|---|---|---|---|---|
| | | | | | |

| Home Phone | Cell Phone | Work Phone | Ext. | Email Address-required for Portal |
|---|---|---|---|---|
| | | | | |

| Race (Check all that apply) | Ethnicity (Choose one) | Language Spoken |
|---|---|---|
| __American Indian/Alaska Native __Black/African American __Asian<br>__Native Hawaiian/Other Pacific Island __Decline to Answer __White | __Hispanic or Latino __Decline to<br>__Not Hispanic or Latino Answer | |

| Student Status | Marital Status | Employment Status |
|---|---|---|
| __Full Time __Not A Student<br>__Part Time | __Single __Life Partner __Separated<br>__Married __Widowed __Divorced | __Full Time __Self Employed __Not Employed<br>__Part Time __Retired |

| Employer Name | Primary Care Doctor | Referring Doctor (If different from PCP) |
|---|---|---|
| | | |

| Emergency Contact Name | Relationship to Patient | Emergency Contact Phone | Would you like to sign up for the Patient Portal? (Circle answer) |
|---|---|---|---|
| | | | Yes No |

## Responsible Party Information (Information used for patient balance statements)

| Responsible Party – if self, skip to next section | First Name | MI | Last Name | Social Security # |
|---|---|---|---|---|
| __Self __Parent __Guarantor | | | | |

| Home Address | City | State | Zip Code | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Home Phone | Email Address | Employer Name | Work Phone | Ext. |
|---|---|---|---|---|
| | | | | |

## Primary Insurance Information

| Insurance Company | Policy Number | Group ID | Copay Amount |
|---|---|---|---|
| | | | |

| Subscriber's Name | Subscriber's Relationship to Patient | Subscriber's Date of Birth |
|---|---|---|
| | | |

## Secondary Insurance Information

| Insurance Company | Policy Number | Group ID | Copay Amount |
|---|---|---|---|
| | | | |

| Subscriber's Name | Subscriber's Relationship to Patient | Subscriber's Date of Birth |
|---|---|---|
| | | |

## Worker's Compensation Information

| Is this a Worker's Comp related injury? | | | Is this accident related? | |
|---|---|---|---|---|
| __Yes __No If yes, fill in the information below | | | __Yes __No | |
| **Injury Date** | **Company Name** | **Company Address** | **Company Phone** | **Company Contact** |
| | | | | |

| Claim # - If Worker's Comp | Describe Injury |
|---|---|
| | |

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. I authorize Rupp Urology LLC to obtain medical records from other physicians, facilities and pharmacies. 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. As the policy holders, I am responsible for knowing the benefits and restrictions of your insurance coverage. I understand that should my insurance company require a REFERRAL/ AUTHORIAZATION prior to my receiving Medical Service and I have not obtained this and/or this office has not received this, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED. **I have read and understand the office policy stated above and agree to accept responsibility as described.**

**Signature:**_____ **Date:**_____

*Revised: 02/23/2018*

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# 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 and Patient Financial Policy.

   _____ _____
   Signature Date

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

| Name | Relation to Patient | Phone Number |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

3. May we contact you and leave messages, possibly containing medical information on your home and/or cell phone, except with basic information. (For example: "please call Rupp Urology" or "you have an appointment with us with date and time"

   ☐ 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**

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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)

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# Patient History and Physical Form

Patient Name:_____ Date of Birth:_____

Chief Complaint:_____

Patient Signature:_____ Date:_____

## Personal Medical History

**Medical:** ( __None) Otherwise, list all past serious illnesses and approximate date. (Examples: HBP, Diabetes, Cancer, Heart Disease)

_____

**Surgery:** ( __None) Otherwise, list type and approximate year> (Examples: Heart, Hernia, Appendectomy)

_____

**Current Prescription Medications:** ( __None) ***If questions, please bring medication bottles with you.***

| Name of Medication | Dose | Name of Medication | Dose |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

Over the counter medicines: (Example: Aspirin, Tylenol, vitamins, herbals) _____

**Allergies:** ( __None that I know of)

**I am allergic to:** (If yes, please explain the type of reaction, i.e., hives, wheezing, upset stomach, selling, 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 | Family History of: | | 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 | If yes, more than 1½ packs per day? | Yes | No |
| Do drink alcohol? | Yes | No | If yes, more than 6 drinks per 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? _____

## Urology History (Circle One)

| | | | | | |
|---|---|---|---|---|---|
| 1. Burning with urination | Yes | No | 7. Need to urinate frequently | Yes | No |
| 2. Notice blood in urine | Yes | No | 8. Urine leakage (Incontinence) | Yes | No |
| 3. Urgency to urinate (feels like you have an urgent need to urinate) | Yes | No | 9. Get up at night to urinate. If yes, how many times? _____ | Yes | No |
| 4. Hesitancy starting to urinate | Yes | No | 10. History of kidney stones | Yes | No |
| 5. Unable to completely empty bladder | Yes | No | 11. Felt lumps in genitalia | Yes | No |
| 6. Unable to urinate at all | Yes | No | | | |

## Review of Systems:

| **Constitutional Systems** | | | **Cardiovascular** | | | **Endocrine** | | |
|---|---|---|---|---|---|---|---|---|
| Fever/Chills | Yes | No | Chest Pain | Yes | No | Excessive Thirst | Yes | No |
| Bad Headaches | Yes | No | Swelling in Ankles | Yes | No | Too hot/Too cold | Yes | No |
| Weight/Appetite Change | Yes | No | High Blood Pressure | Yes | No | Tired/Sluggish | Yes | No |
| Other:_____ | | | Other:_____ | | | Other:_____ | | |

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**Review of Systems Continued:**

| **Respiratory** | | | **Hematologic/Lymphatic** | | | **Ear/Nose/Throat/Mouth** | | |
|---|---|---|---|---|---|---|---|---|
| Wheezing | Yes | No | Swollen Glands | Yes | No | Ear Infection | Yes | No |
| Frequent Cough | Yes | No | Blood Clotting Problems | Yes | No | Sore Throat | Yes | No |
| Shortness of Breath | Yes | No | Excessive Bruising | Yes | No | Sinus Problem | Yes | No |
| Other:_____ | | | Other:_____ | | | Other:_____ | | |
| **Neurological** | | | **Gastrointestinal** | | | **Musculoskeletal** | | |
| Tremors | Yes | No | Abdominal Pain | Yes | No | Joint Pain | Yes | No |
| Dizzy Spells | Yes | No | Nausea/Vomiting | Yes | No | Neck Pain | Yes | No |
| Numbness/Tingling | Yes | No | Indigestion/Heartburn | Yes | No | Back Pain | Yes | No |
| Stroke | Yes | No | Constipation/Diarrhea | Yes | No | Loss of Strength | Yes | No |
| Other:_____ | | | Other:_____ | | | Other:_____ | | |
| **Allergic/Immunologic** | | | **Eyes** | | | **Psychological** | | |
| Hay Fever | Yes | No | Blurred Vision | Yes | No | Depression | Yes | No |
| Drug Allergies | Yes | No | Double Vision | Yes | No | Anxiety over Condition | Yes | No |
| Other:_____ | | | Other:_____ | | | Other:_____ | | |
| **Integumentary** | | | **Females Only:** | | | | | |
| Skin Rash | Yes | No | Pregnancy History (if applicable): | | | | | |
| Boils | Yes | No | Number of Pregnancies:_____ | | | | | |
| Persistent Itch | Yes | No | Number of Vaginal Deliveries:_____ | | | | | |
| Other:_____ | | | Hysterectomy Age: | | | | | |

**Prostate System Score** ***** MALES ONLY *****

| **Over the Past Month** | **Not at all** | **Less than 1 time in 5** | **Less than ½ the time** | **About ½ the time** | **More than ½ the time** | **Almost Always** |
|---|---|---|---|---|---|---|
| **Incomplete Emptying:** How often have you had the sensation of not emptying your bladder completely after you have finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Frequency:** How often have you had to urinate again less than 2 hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Intermittency:** How often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Urgency:** How often do you find it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Weak Stream:** How often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Straining:** How often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Sleeping:** How many times do you most typically get up to urinate from the time you go to bed at night until the time you get up in the morning? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Add Symptom Scores:** | | | | | | |

**Total Prostate Symptom Score = _____**

**1-7 mild symptoms | 8-19 moderate symptoms | 20-35 severe symptoms**

| **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 |

Have you tried medications to help your symptoms? Yes No

| Did these medications help your symptoms? (circle) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

*No Relief* *Completely Cured*