

Dr. Michael J. Finger, M.D.
Medical History

Name _____

Today's Date _____

Age: _____

Date of Birth: _____

Have you ever had any prior Urologic history or have you seen an Urologist in the past?

No _____

Yes _____ if Yes Explain _____

Have you ever seen blood in urine before?

No _____

Yes _____ if Yes Explain _____

Have you ever had kidney stones before?

No _____

Yes _____ if Yes Explain _____

Have you ever had a history of urinary incontinence or leaking urine?

No _____

Yes _____ if Yes Explain _____

Do you or your family have a history of Prostate, Kidney, or Bladder Cancer?

No _____

Yes _____ if Yes Explain _____

Have you ever had any allergies or reaction to drugs or medications in the past?

No _____

Yes _____ if Yes Explain _____

Have you ever had any allergies or reactions to IVP/Intravenous X-ray Contrast?

No _____

Yes _____ if Yes Explain _____

Do you or your family have a history of Heart Disease, Diabetes, High Blood Pressure Etc?

No _____

Yes _____ if Yes Explain _____

Do you smoke? No If Yes How Often _____

Do you drink Alcoholic Beverages? No Yes If yes, How Often _____

Please list all **MEDICATIONS** you take regularly and or ANY "over the counter" **MEDICATIONS** taken the last 7 days.

Please list **ANY SURGICAL** Procedures:

Year _____

Year: _____

Year _____

Year: _____

Year _____

Year: _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms.

- Fever Y N
- Headache Y N
- Chills Y N
- Other _____

Eyes

- Blurred Vision Y N
- Double Vision Y N
- Pain Y N
- Other _____

Allergic/Immunologic

- Hay Fever Y N
- Drug allergies Y N
- Other _____

Neurological

- Tremors Y N
- Numbness/tingling Y N
- Dizzy spells Y N
- Other _____

Endocrine

- Excessive thirst Y N
- Tired/sluggish Y N
- Too hot/cold Y N
- Other _____

Gastrointestinal

- Abdominal Pain Y N
- Indigestion/Heartburn Y N
- Nausea/Vomiting Y N
- Other _____

Cardiovascular

- Chest Pains Y N
- Varicose veins Y N
- High blood Pressure Y N
- Other _____

Integumentary

- Skin rash Y N
- Boils Y N
- Persistent itching Y N
- Other _____

Musculoskeletal

- Joint pain Y N
- Back pain Y N
- Neck pain Y N
- Other _____

Ear/Nose/Throat/Mouth

- Ear infection Y N
- Sinus problems Y N
- Sore throat Y N
- Other _____

Genitourinary

- Urine retention Y N
- Urinary frequency Y N
- Painful urination Y N
- Other _____

Respiratory

- Wheezing Y N
- Shortness of breath Y N
- Frequent cough Y N
- Other _____

Hematologic/Lymphatic

- Swollen glands Y N
- Blood clotting problem Y N
- Other _____

Psychologic

- Are you generally satisfied with you life? Y N
- Do you feel severely depressed? Y N
- Other _____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5

Physician: _____ Date: ____/____/____

Could your male urinary symptoms be caused by BPH?

Answer these simple questions and share them with your doctor.

American Urological Association (AUA) Symptom Index for BPH

1. INCOMPLETE EMPTYING

Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

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
0	1	2	3	4	5

2. FREQUENCY

During the last month, how often have you had to urinate again less than 2 hours after you finished urinating?

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
0	1	2	3	4	5

3. INTERMITTENCY

During the last month, how often have you stopped and started again several times when you urinated?

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
0	1	2	3	4	5

4. URGENCY

During the last month, how often have you found it difficult to postpone urination?

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
0	1	2	3	4	5

5. WEAK STREAM

During the last month, how often have you had a weak urinary stream?

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
0	1	2	3	4	5

6. STRAINING

During the last month, how often have you had to push or strain to begin urination?

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
0	1	2	3	4	5

7. NOCTURIA

During 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 got up in the morning?

Never	1 time a night	2 times a night	3 times a night	4 times a night	5 times or more a night
0	1	2	3	4	5

Now add up your Symptom Score (1-7 Mild, 8-19 Moderate, 20-35 Severe):

Name and date:

Adapted from American Urological Association. *Guideline on the Management of Benign Prostatic Hyperplasia (BPH)*. Linthicum, MD: American Urological Association Education and Research, Inc; 2003:1-22,1-23,3-51.

The Disease Specific Quality of Life Question

The International Prostate Symptom Score uses the same 7 questions as the AUA Symptom Index (presented above) with the addition of the following Disease Specific Quality of Life Question (bother score) scored on a scale from 0 to 6 points (delighted to terrible).

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

Delighted	Pleased	Mostly satisfied	Mixed	Mostly disappointed	Unhappy	Terrible
0	1	2	3	4	5	6

FLOMAX is approved to treat male urinary symptoms due to BPH, also called an enlarged prostate. Only your doctor can tell if you have BPH, not a more serious condition like prostate cancer. Avoid driving or hazardous tasks for 12 hours after your first dose or increase in dose, as a sudden drop in blood pressure may occur, rarely resulting in fainting. If considering cataract surgery, tell your eye surgeon you've taken FLOMAX. Common side effects are runny nose, dizziness and decrease in semen. **To learn more, call 866-432-9734 or visit 4FLOMAX.com.**

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Talk to your doctor for more information, or visit 4FLOMAX.com.

Please see accompanying Patient Information and full Prescribing Information.

If you can't afford FLOMAX, our Patient Assistance Program may help. Call 800-556-8317.

FLOMAX[®]
TAMSULOSIN HCl CAPSULES 0.4 mg

**PRIVACY PRACTICE ACKNOWLEDGEMENT/PATIENT
CONSENT FORM**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* form time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

DIRECT ASSIGNMENT OF BENEFITS

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this ____ day of _____, 20____

Signature of Policyholder

Witness

*****I, _____ UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

SIGNATURE

DATE

**Michael J. Finger M.D. P.A.
2501 N Navarro
Victoria, Texas 77901**

**I _____ give my permission to Dr. Finger
and/or any of his staff to release my information to the following people:**

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Information may be left at my: ___ home ___ work

A message may be left on my machine at ___ home ___ work

**I understand that the above information must be given for the new
HIPAA regulations. I understand also that anyone not listed on this
form can not and will not be given any information.**

**Patient
Signature _____**

Date _____ Witness _____