Affix Label Here

MINNESOTA UROLOGY

Patient Authorization and Consent Form

Consent for Treatment: I consent to and authorize my health care provider to examine and treat me. I understand this could include lab tests or other diagnostic procedures, education or images which may result in separate billable charges. I understand my provider is available to explain the purpose of the procedure(s) and treatment(s), and I have the right to refuse such procedure(s) or treatment(s).

- o I authorize Minnesota Urology (MNU) to verbally communicate regarding my personal health care or billing information with me by leaving voicemail messages on phone number: _____.

Privacy: I acknowledge I have received a copy or have been made aware of MNU's privacy practices. I understand I may request a copy of this notice. I authorize MNU to discuss and disclose health care/billing information to others as provided below:

- o I authorize MNU to verbally communicate regarding my personal health care or billing information with:
  Name: _____Relationship:_____

Assignment of Benefits and Release of Information: I request payment of authorized benefits directly to the provider for services rendered to me at this facility or other facility owned or operated by MNU, including physician services, any provider under contract with MNU or participating in a provider network in which MNU or its affiliates participates. I consent to MNU releasing my health records and other information related to my health care services for payment and healthcare operational purposes. I agree that MNU may release my health records and other information to my insurance company.

Release of Information by Payers and Networks: I authorize Medicare, my insurance company or HMO, other payers, payer network organizations including accountable care organizations, their contractors and 3rd party administrators to share my health records and information obtained by MNU or any other provider, with MNU, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and 3rd party administrators of these parties as needed for payment and health care operations.

Release of Information to Health Care Providers: I consent to the release of my health records created and received by MNU for my treatment to other health care providers who are involved in my treatment.

Lab Billing/Outside Lab Billing: I understand that if my provider decides to order lab work during my visit, some tests may require evaluation by an outside (third party) laboratory. In this case, I understand I may receive a separate bill from the outside lab.

Payment Agreement: I understand that I am financially responsible for and agree to promptly pay any charges for the care and treatment of non covered services rendered to me that are not covered by my insurance plan. If I do not have active insurance coverage, I understand: 1) my billing status will be listed as 'self-pay,' 2) I will be required to make a $100 down payment prior to receiving an evaluation and treatment, and 3) I will be billed for the remainder of all charges related to my evaluation and treatment. Regardless of insurance coverage, I understand my past due balances may be assessed a finance charge.

No Show/Late Cancellation Policy: I acknowledge that by not cancelling my appointment in at least 24 hours in advance or not showing up for your appointment prevent other patients from being scheduled. I understand I may be assessed a $100 fee for each missed appointment after my second *Office Visit* no-show Further, I understand that I will be assessed a $50 fee for any *Procedure* no show appointment or late cancel for any appointment.

When electronically signing this form, I acknowledge I have read and agree to all of the above.

You may withdraw this consent at any time by advising us in writing at: Minnesota Urology, 6025 Lake Road, Suite 200, Woodbury MN, 55125. I understand my revocation shall have no effect on releases that have already been completed.

_____

Signature of Patient/Personal Representative | Print Patient Name | Date of Birth | Today's Date

_____ _____

Relationship to Patient (if patient unable to sign) | Reason Patient Unable to Sign

METROUROLOGY

Fertility Questionnaire

In order to assess your fertility and to give you the best medical treatment possible, we would appreciate your completion of this questionnaire. There is also a section for your partner to complete as well. All information will be held in strict confidence. Please bring this completed questionnaire with you on your first visit.

Please bring with you any records (semen analyses, doctor's notes, etc) pertaining to prior fertility evaluations.

If you do not have a spouse/partner or are not currently trying to establish a pregnancy, simply omit the irrelevant questions.

Patient (Male)

Height _____ Weight _____

Pharmacy name, address, phone number _____

Telephone number to patient contacted: (H) _____(Cell) _____

Employment/Occupation:_____

Emergency contact: Name _____ Phone _____

Who referred you for this consultation? (Self? Doctor? If so, from what clinic?) _____

_____

Day time phone_____ Evening phone _____

Do we have your permission to communicate our findings with your partner's/wife's gynecologist to facilitate the establishment of a pregnancy? ☐ Yes ☐ No ☐ Not Applicable

Years married/years with partner: _____ Years trying to conceive: _____

Previous birth control method with current partner: _____

Previous pregnancies with spouse/partner:

Live births (0-9) _____ Miscarriages (0-9) _____ Abortions (0-9) _____

Previous pregnancies with someone other than your spouse or partner:

Live births (0-9) _____ Miscarriages (0-9) _____ Abortions (0-9) _____

Spouse / Partner Information (Please fill in for your partner or have her do so)

Name: _____ Birth date: ____/____/____ Age: _____

Previous pregnancies with any OTHER partners (not including spouse/current partner :)

Live births (0-9) _____ Miscarriages (0-9) _____ Abortions (0-9) _____

List any history of medical/gynecological problems (e.g. pelvic or vaginal infections, fibroids, and endometriosis):

_____

Do you have regular menstrual cycles/periods? ☐ Yes ☐ No

Have you been evaluated for infertility? ☐ Yes ☐ No

If yes, physician's name and address: _____

_____

❖ ***Tests performed:***

Ultrasound	☐ Normal	☐ Abnormal	☐ Not done
Hysterosalpingogram ("dye test")	☐ Normal	☐ Abnormal	☐ Not done
Laparoscopy	☐ Normal	☐ Abnormal	☐ Not done
Hormone levels	☐ Normal	☐ Abnormal	☐ Not done
Postcoital test	☐ Normal	☐ Abnormal	☐ Not done
Other: _____	☐ Normal	☐ Abnormal	☐ Not done

Please list any treatment for infertility and dates (i.e., Clomid, Pergonal, IVF, GnRH, HCG injections, Progesterone, intrauterine inseminations,): _____

_____

_____

Sexual History

On average, how frequently do you have intercourse? _____ times per month

How often do you have intercourse around the time of your wife's/partner's ovulation?
☐ Daily ☐ Every other day ☐ Less than every other day ☐ Ovulation unpredictable

On average, how often do you masturbate? _____ times per month

Do you have any problems getting or maintaining an erection? If yes, please specify: ☐ Yes ☐ No _____

Do you have any problems with ejaculation? If yes, please specify: ☐ Yes ☐ No _____

Do you use any form of lubrication for intercourse? If yes, what kind: ☐ Yes ☐ No _____

Is intercourse ever painful for you or your partner? If yes, please specify: ☐ Yes ☐ No _____

Have you noticed any change in your sexual desire or drive? If yes, please specify: ☐ Yes ☐ No _____

Fertility History

❖ ***Do you presently have or have you ever had any of the following:***

Did you have undescended testicles at birth? ☐ Yes ☐ No If yes, Right ___ Left ___ Bilateral ___
(some boys are born with their testicles in their abdomen)

Have you ever had a hernia operation? ☐ Yes ☐ No If yes, Right ___ Left ___ Bilateral ___

Approximately, at what age did you start going through puberty? _____

Have you ever had the mumps? ☐ Yes ☐ No Did you have the mumps after puberty? ☐ Yes ☐ No

❖ ***Have you ever had any of the following?***

Diabetes (sugar) ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Neurological disorders (e.g. Multiple Sclerosis) ☐ Yes ☐ No

Cystic Fibrosis ☐ Yes ☐ No

Bladder or pelvic surgery ☐ Yes ☐ No

Have you ever had a urinary tract infection? ☐ Yes ☐ No

Have you ever had a prostate infection? ☐ Yes ☐ No

Have you ever had an infection in the testicles or epididymis? ☐ Yes ☐ No

Have you ever had blood in your ejaculate (semen)? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No If yes, what type:_____

Have you ever had white, green or yellow discharge from the end of your penis? ☐ Yes ☐ No

❖ ***Have you ever had surgery for:***

Vasectomy? ☐ Yes ☐ No

Varicocelectomy (tying off dilated veins to the scrotum)? ☐ Yes ☐ No

Testicular or scrotal surgery? ☐ Yes ☐ No

Penis surgery? ☐ Yes ☐ No

Have you ever had trauma (injury) to your testicles? ☐ Yes ☐ No
If yes, please specify: _____

_____

Do you have any problems with urination (i.e. reduced flow, urgency, etc.) ☐ Yes ☐ No If yes, please describe:

_____

Have you ever taken steroids? ☐ Yes ☐ No

Have you ever taken testosterone supplements? ☐ Yes ☐ No

Have you ever had any chemotherapy? ☐ Yes ☐ No

Have you ever had radiation therapy or been exposed to radiation (other than routine x-rays)? ☐ Yes ☐ No

Do you frequently take hot baths, saunas, or steam baths, Or are you exposed to temperature extremes (hot or cold)? ☐ Yes ☐ No

Have you ever been exposed to chemicals, solvents and their fumes, or any toxins/poisons (e.g., pesticides)? ☐ Yes ☐ No

Do you frequently get colds, upper respiratory tract infections or sinus infections? ☐ Yes ☐ No

Have you had a fever or viral illness within the past year? ☐ Yes ☐ No If yes, when? _____

Do you have significant problems with your sense of smell? ☐ Yes ☐ No

Have you noticed any problems with your peripheral vision? ☐ Yes ☐ No

Have you noticed any secretions or tenderness in your breasts? ☐ Yes ☐ No

Do you have any testicular pain or discomfort? ☐ Yes ☐ No

Have you had any prior evaluations for infertility? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Family Fertility History

Do you think any of your relatives had trouble conceiving? ☐ Yes ☐ No ☐ Unknown
If yes, please explain why you think so (indicate the relative): _____

_____

Are you adopted? ☐ Yes ☐ No ☐ Unknown

How many brothers do you have? _____ Do they have children? ☐ Yes ☐ No

What year(s) were your brothers born? _____

How many sisters do you have? _____ Do they have children? ☐ Yes ☐ No

What year(s) were your sisters born? _____

Are any of your brothers or sisters adopted? ☐ Yes ☐ No ☐ Unknown
If yes, please specify which ones: _____

Do you think any of your siblings (brothers or sisters) had trouble conceiving? ☐ Yes ☐ No ☐ Unknown
If yes, please explain why you think so (include which sibling(s) and any known medical causes):

_____

_____

Are there any known miscarriages in your family or relatives: ☐ Yes ☐ No ☐ Unknown
If yes, please specify: _____

_____

Are there any medical (i.e. heart disease, cancer, diabetes) or genetic diseases, which run in your family? If so, please describe:

Relative	Disease/Disorder
_____	_____
_____	_____

Past Medical History

Are you having problems (now or in the past) with any of the following? ☐ No ☐ Yes If yes, please check all boxes that apply.

- Anemia ☐
- Arthritis ☐
- Asthma ☐
- Cancer ☐
  - Type of cancer: _____
- Depression ☐
- Diabetes ☐
- GERD / Acid Reflux ☐
- Gout (high uric acid) ☐
- Heart Disease ☐
- High Blood Pressure ☐
- High Cholesterol ☐
- Kidney Stones ☐
- Liver Disease ☐
- Mitral Valve Prolapse ☐
- Osteoporosis ☐
- Rheumatic Fever ☐
- Thyroid Problems ☐
- Toxic Exposure ☐
- Tuberculosis ☐
- Other/Explain: _____

_____

Past Surgical History

Have you had **surgery** on any of the following? ☐ No ☐ Yes If yes, please check all boxes that apply.
INCLUDE THE SURGERY DATE:

Appendix ☐
Back ☐
Bladder ☐
Breast ☐
Colon ☐
Gallbladder ☐
Heart Bypass ☐
Heart Valve ☐
Hernia ☐
Incontinence ☐
Kidney ☐
Lung ☐
Prostate ☐
Testicle ☐
Thyroid ☐
Total Joint Replacement
Right: ☐ Hip ☐ Knee ☐ Shoulder
Left: ☐ Hip ☐ Knee ☐ Shoulder
Knee ☐
Urethra ☐
Vasectomy ☐
Other/Explain: _____

_____

Allergies

Do you have any allergies? ☐ Yes ☐ No If yes, please list the allergy and type of reaction: _____

_____

_____

Latex allergy? ☐ Yes ☐ No Have you ever had MRSA? ☐ Yes ☐ No Positive Mantoux/PPD? ☐ Yes ☐ No

Medications

Are you taking Aspirin, Coumadin, blood thinners? ☐ Yes ☐ No

Please list any <u>prescription medications</u> you currently or frequently take: _____

_____

_____

_____

Please list any <u>over-the-counter medications – including herbal therapies</u> you currently or frequently take:

_____

_____

_____

Social History

Bolded questions in this section are Government required due to the Health Care Reform Act.
What language do you speak? _____Race?_____
Ethnicity? ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Marital Status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Do you or did you ever smoke? ☐ Yes ☐ No If yes, how long (yrs) _____ Number of packs/day _____
Use smokeless tobacco? ☐ Yes ☐ No
When did you quit smoking? _____

❖ ***Do you now or have you ever used any of the following drugs?***

Caffeine	☐ Yes ☐ No	Amount _____	Frequency _____
Alcohol	☐ Yes ☐ No	Amount _____	Frequency _____
Marijuana	☐ Yes ☐ No	Amount _____	Frequency _____
Others	☐ Yes ☐ No	Amount _____	Frequency _____

Have you had a blood transfusion? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Constitutional Symptoms

Fever	☐ No	☐ Yes
Chills	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Weight Loss	☐ No	☐ Yes
Weight Gain	☐ No	☐ Yes
Other _____	☐ No	☐ Yes

Eyes

Blurred vision	☐ No	☐ Yes
Double vision	☐ No	☐ Yes
Pain	☐ No	☐ Yes
Other _____	☐ No	☐ Yes

Endocrine

Excessive thirst	☐ No	☐ Yes
Too hot/cold	☐ No	☐ Yes
Tired/sluggish	☐ No	☐ Yes
Other _____	☐ No	☐ Yes

Cardiovascular

Chest pain	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes
Other _____	☐ No	☐ Yes

Integumentary

Skin rash	☐ No	☐ Yes
Boils	☐ No	☐ Yes
Other _____		
Persistent itch	☐ No	☐ Yes

Respiratory

Wheezing	☐ No	☐ Yes
Frequent cough	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes

Other _____

Gastrointestinal

Abdominal pain	☐ No	☐ Yes
Nausea/vomiting	☐ No	☐ Yes
Indigestion/Heartburn	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Irritable bowel	☐ No	☐ Yes

Other _____

Musculoskeletal

Joint pain	☐ No	☐ Yes
Neck pain	☐ No	☐ Yes
Back Pain	☐ No	☐ Yes

Other _____

Neurological

Tremors	☐ No	☐ Yes
Dizzy spells	☐ No	☐ Yes
Numbness/Tingling	☐ No	☐ Yes
Headache	☐ No	☐ Yes

Other _____

Genitourinary

Urine retention	☐ No	☐ Yes
Painful Urination	☐ No	☐ Yes
Urinary frequency	☐ No	☐ Yes

Urinary tract infections

If yes, # per year_____

Ear/Nose/Throat/Mouth

Ear Infection	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes
Sinus problems	☐ No	☐ Yes

Other_____

Allergic/Immunologic

Hay fever	☐ No	☐ Yes
Drug allergies	☐ No	☐ Yes
Other _____	☐ No	☐ Yes

Hematologic/Lymphatic

Swollen glands	☐ No	☐ Yes
Blood clotting	☐ No	☐ Yes
Pulmonary embolism	☐ No	☐ Yes

Sexual History

Sexually active?	☐ No	☐ Yes
Pain with intercourse?	☐ No	☐ Yes
Leaking urine with intercourse?	☐ No	☐ Yes

Psychologic

Are you generally satisfied with your life?	☐ No	☐ Yes
Are you depressed?	☐ No	☐ Yes
Have you ever considered suicide?	☐ No	☐ Yes

Physician use only: (Comments)