



Lake Sumter Urology

808, Hwy 466 • Lady Lake, FL 32159

Tel: 352.775.6899 • Fax: 352.775.8125

lakesumterurology.com

Patient Information

- Full Name: _____
- Date of Birth: _____
- Sex: ☐ Male ☐ Female Please circle: Married Divorced Single Widow
- Phone Number: _____ Cell Number: _____
- Email Address: _____
- Pharmacy Name And Location: _____

Home Address: _____

- Emergency Contact Name: _____
- Emergency Contact Phone: _____
- Primary Care Provider: _____
- Referring Provider (if any): _____

Insurance Information

- Primary Insurance Carrier: _____
- Policy Number: _____
- Group Number: _____
- Policy Holder Name: _____
- Relationship to Patient: _____

Medical History

Current Symptoms (check all that apply)

- ☐ Frequent urination
- ☐ Pain or burning with urination
- ☐ Blood in urine
- ☐ Incontinence or leakage
- ☐ Trouble starting or stopping urine stream
- ☐ Nocturia (nighttime urination)
- ☐ Pelvic or flank pain
- ☐ Erectile dysfunction
- ☐ Testicular pain or swelling
- ☐ Other: _____

Past Urologic Conditions (check all that apply)

- ☐ Kidney stones
- ☐ Recurrent UTIs
- ☐ Enlarged prostate/BPH
- ☐ Prostate cancer
- ☐ Bladder cancer
- ☐ Overactive bladder
- ☐ Interstitial cystitis
- ☐ Incontinence
- ☐ Other: _____

Surgical History

- **List all past surgeries:**

Medications

- **List current medications and dose:** _____

Allergies

- **List medication or material allergies:**

Social History

- **Tobacco Use:** ☐ Never ☐ Former ☐ Current
- **Alcohol Use:** ☐ None ☐ Occasional ☐ Regular
- **Recreational Drugs:** ☐ Yes ☐ No — If yes: _____

Family History

Check any conditions in immediate family:

- ☐ Kidney stones
- ☐ Prostate cancer
- ☐ Bladder cancer
- ☐ Kidney disease
- ☐ Incontinence

Review of Systems

Please check any symptoms you are experiencing:

- **General:** ☐ Fever ☐ Fatigue ☐ Weight loss
- **Cardiac:** ☐ Chest pain ☐ Palpitations

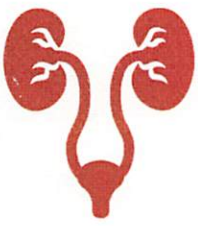
- **Respiratory:** ☐ Shortness of breath ☐ Cough
 - **GI:** ☐ Nausea ☐ Constipation ☐ Diarrhea
 - **Musculoskeletal:** ☐ Back pain ☐ Joint pain
 - **Neurological:** ☐ Dizziness ☐ Numbness
-

Consent to Treat

I consent to evaluation and treatment by the urology providers at this clinic. I understand that this may include physical examinations, diagnostic tests, and medical or surgical recommendations.

Signature: _____

Date: _____



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ASSIGNMENT OF BENEFITS

Medicare, Medigap, General Assignment of Benefits and receipt of HIPPA information

I request the payment of any of the above payments be made on my behalf to Lake Sumter Urology, LLC for any services rendered to me by my provider. I have received the HIPPA patient privacy rights, and I am aware of my privacy rights and how to exercise them.

Print Signature

Patient Signature

Date

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

Please list who we can discuss your information with.

NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

I understand that under the Health Insurance Portability and Accounting 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 healthcare providers who may be involved in that treatment directly or indirectly
- Electronically exchange records with other healthcare providers and organizations
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis
- Access drug benefit coverage and medication history

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from 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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

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

Patient Name: _____

Patient Signature: _____

Date: _____

Inability to Obtain Acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe in good faith efforts made to obtain the individual's acknowledgment and the reasons why the acknowledgment was not obtained.

LSU, LLC. Signature: _____

Date: _____



Ph: 352-775-6899
Fax: 877-319-1879

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The Questionnaire for female Urinary Incontinence Diagnosis (QUID)

	None of the time	Rarely	Once in a while	Often	Most of the time	All of the time
Do you leak urine (even small drops), wet yourself, or wet your pads or undergarments...						
1. when you cough or sneeze?	☐	☐	☐	☐	☐	☐
2. when you bend down or lift something up?	☐	☐	☐	☐	☐	☐
3. when you walk quickly, jog or exercise?	☐	☐	☐	☐	☐	☐
4. while you are undressing in order to use the toilet?	☐	☐	☐	☐	☐	☐
5. Do you get such a strong and uncomfortable need to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?	☐	☐	☐	☐	☐	☐
6. Do you have to rush to the bathroom because you get a sudden, strong need to urinate?	☐	☐	☐	☐	☐	☐

Scoring:

Each item scores 0 (None of the time), 1 (Rarely), 2 (Once in a while), 3 (Often), 4 (Most of the time) or 5 (All of the time). Responses to items 1, 2 and 3 are summed for the Stress score; and responses to items 4, 5, and 6 are summed for the Urge score.