Prescription History Download Consent

_____ I hereby authorize Mesa Urologists, A Division of Ironwood Physicians, P.C. to download my prescription history from my pharmacy. I understand I have the right to revoke this authorization at any time by submitting a request in writing.

_____ I hereby do NOT authorize Mesa Urologists, A Division of Ironwood Physicians, P.C. to download my prescription history from my pharmacy. I understand I have the right to revoke this authorization at any time by submitting a request in writing.

Patient Printed Name: _____ BirthDate: _____

Patient Signature: _____ Date: _____

MESA UROLOGISTS

A DIVISION OF IRONWOOD PHYSICIANS, P.C.

Patient Demographic Information

Patient Information

Name: _____ ○ Male ○ Female DOB: _____

Address: _____

Is Arizona your permanent Residence: ○ Yes ○ No

Alt Address: _____ _____

Social Security: _____ Martial Status: _____

Contact

Home: _____

Cell: _____

Work: _____

Other: _____

Preferred Method of Contact

Ok to Leave Message: ○ Yes ○ No

☐ Home ☐ Cell ☐ Work ☐ Other ☐ Email

Email: _____

Are You Currently Working: ○ Yes ○ No

Disabled: ○ Yes ○ No Retired: ○ Yes ○ No

Current/Former Occupation or Employer: _____

Responsible Party Other than Patient

Name: _____ Relationship: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Phone: _____

Insured Name: _____ DOB: _____

Group#: _____ Policy#: _____

Secndary Insurance: _____ Phone: _____

Insured Name: _____ DOB: _____

Group#: _____ Policy#: _____

Patient Signature/Responsibility Party: _____ Date: _____

MESA UROLOGISTS

A DIVISION OF IRONWOOD PHYSICIANS, P.C.

Financial Policy/Assignment of Benefits For Patients

- I understand that I have medical insurance which when billed on my behalf should pay for their portion of my office visits and treatment charges. _____ initials
- I will inform Ironwood Physicians, PC or Ironwood Cancer and Research Centers of a change in my insurance coverage. _____ initials
- I understand the billing process may take 4-6 weeks at which time may insurance company will determine and pay for services per my contract. _____ initials
- I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company. _____ initials
- I understand that I will leave my credit card information to be kept on file and that if I do not pay within **60 days** after my insurance has paid, I acknowledge that Ironwood Physicians, PC and Ironwood Cancer and Research Centers will charge the balance to the credit card on file. _____ initials
- I understand that if for any reason my insurance company does not pay for the covered services within **90 days** of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on file. _____ initials
- I thereby assign all medical benefits directly to Ironwood Physicians, PC and Ironwood Cancer and Research Centers for services rendered at the facilities. _____ initials
- I understand if a CT or PET/CT scan is completed it will be necessary for a licenced Radiologist to interpret or read your scan results. You will be receiving two statements for your CT or PET/CT scan for their professional interpretation of the CT or PET/CT scan separate of Ironwood. _____ intials
- We may request proof of insurance premium payment. _____ initials
- I have read and received a copy, if desired, of this document. _____ initials

Patient Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Consent to Release Protected Health Information Contact List

Patient Name: _____ DOB: _____ Date: _____

Initials _____ **I authorize Ironwood Physicians, PC to use/disclose my personal health information to the individuals listed on his form**

Initials _____ I understand that Ironwood Physicians, PC staff may leave detailed messages on my voicemail.

1. **Contact Name: (Emergency Contact)** _____

Phone: _____ Address: _____

Relationship: ☐ Spouse ☐ Family (Describe) _____ ☐ Friend ☐ Other (Describe) _____

1. **Contact Name: (Emergency Contact)** _____

Phone: _____ Address: _____

Relationship: ☐ Spouse ☐ Family (Describe) _____ ☐ Friend ☐ Other (Describe) _____

1. **Contact Name: (Emergency Contact)** _____

Phone: _____ Address: _____

Relationship: ☐ Spouse ☐ Family (Describe) _____ ☐ Friend ☐ Other (Describe) _____

I hereby authorize Ironwood Physicins, PC.to use and disclose my personal health information to the Individuals Identified on this form.
I understand this authorization does not expire unless written notice is malled to P.O. Box 6423 Chandler AZ, 85246.
I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.
I understand that the individual identified on this form will be treated by Ironwood Physicians PC as individuals involved directly in my care and as such, Ironwood Physicians, PC will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.
I understand that I have a right to request and receive a Notice of privacy Practices from Ironwood Physicians, PC.
I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorizaion, and I understand that my ability to obtain health care from Ironwood Physicians PC will not be affected if I refuse to sign this authorization.

Physician's Signature: _____ Date: _____

Persoanl Representative Signature: _____ Date: _____

Relationship to Patient: _____

Mesa Urologists
Medical History Questionnaire

Who referred you here? (Print name) ☐ Physician ☐ Friend ☐ Relative

Have you ever had following?
- ☐ Blood in the urine
- ☐ Kidney stones
- ☐ Infection of bladder or kidney

In the last year have you had incontinence of urine?
- ☐ Urine loss with cough or sneeze
- ☐ Unexpected urine loss
- ☐ Use of pads per day _____

In the last year did you have any voiding problems?
- ☐ Frequent urination
- ☐ Getting up _____ times to urinate at night
- ☐ Difficulty to postpone urination
- ☐ Pain and discomfort while urinating
- ☐ Burning with urination
- ☐ Incomplete bladder emptying
- ☐ Delay in starting urination
- ☐ Weak urinary stream
- ☐ Straining with urination
- ☐ Stream starts and stops repeatedly

Do you have problems in your sexual life?
- ☐ Deminished sexual drive
- ☐ Loss of sexual arousal

Male Only
- ☐ Penile discharge
- ☐ Erection not hard enough for penetration (entering your partner)

Female only
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Vaginal abnormalities

Have you had any of the following problems in the last year?

GENERAL
- ☐ Excessive fatigue
- ☐ Unexplained loss of weight
- ☐ Chills or fever

EYES
- ☐ Changes in your vision
- ☐ Double or ☐ blurred vision
- ☐ Glaucoma
- ☐ Cataract
- ☐ Glasses or contact lenses

EARS, NOSE AND THROAT
- ☐ Hearing loss
- ☐ Hearing aid
- ☐ Nose bleeds
- ☐ Running nose (rhinitis)
- ☐ Blocked sinuses
- ☐ Frequent colds and sore throat

DIGESTIVE TRACT
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Gas or bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black or bloody bowel movements
- ☐ Hemorrhoids

MUSCLE, BONES & JOINTS
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Muscle ache
- ☐ Muscle weakness
- ☐ Broken bones

NEUROLOGICAL
- ☐ Trouble sleeping
- ☐ Trembling hands
- ☐ Numbness or tingling
- ☐ Shooting pains
- ☐ Black out spells
- ☐ Dizziness
- ☐ Seizures

PSYCHIATRIC
- ☐ Worries and fears
- ☐ Depress feelings
- ☐ Tension at home or work
- ☐ Nervous break down
- ☐ Psychiatric care or treatment

CARDIOVASCULAR SYSTEM
- ☐ Chest pain or tightness
- ☐ Shortness of breath
- ☐ Rapid or irregular heart beats
- ☐ High blood pressure
- ☐ Foot and ankle swelling
- ☐ Leg distress while walking
- ☐ Varicose veins

RESPIRATORY SYSTEM
- ☐ Wheezing or asthma
- ☐ Chronic persistent cough
- ☐ Coughing of Blood
- ☐ Pneumonia

SKIN
- ☐ Itching of the skin
- ☐ Skin rash
- ☐ Boils
- ☐ Non healing sores
- ☐ Jaundice (yellow skin and eyeballs)
- ☐ Dry skin and hair

LYMPHATIC & HEMATOLOGICAL
- ☐ Anemia
- ☐ Easy bruising or bledding
- ☐ Blood clot in your legs or lungs
- ☐ Enlarged lymph glands
- ☐ Blood transfusion
- ☐ Cortisone medication

ENDOCRINE SYSTEM
- ☐ Excessive thirst
- ☐ Feeling colder than others
- ☐ Feeling warmer than others
- ☐ Diabetes
- ☐ Thyroid dysfunction

OBSTETRICAL HISTORY

Pregnancies: _____

Childbirths: _____

Miscarriage: _____

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Menstruating

Date last menstrual period began _____

Patient Name: _____ Age: _____ Date: _____

I personally reviewed this form with the patient: _____

Mesa Urologists Medical History Questionnaire

CHRONIC HEALTH PROBLEMS	Since	SURGERIES	Date
1)		1)	
2)		2)	
3)		3)	
4)		4)	
5)		5)	
6)		6)	
HOSPITALIZATIONS	**Date**	INJURIES	**Date**
1)		1)	
2)		2)	
3)		3)	

List all drugs you presently use regularly or take occasionally

MEDICATION	Strength	Dose
1)		
2)		
3)		
4)		
5)		

NEW ALLERGIES

☐ No allergies known

Are you allergic to

☐ Penicillin ☐ Sulfa drugs

☐ Codeine or Morphine

☐ Latex ☐ Adhesive tape

☐ Lodine (shellfish, contrast)

List other allergies

1) _____

2) _____

3) _____

Please provide approximate date of the most recent events of the following if applicable:

Mammogram: _____

Colonoscopy: _____

Dexa Scan: _____

Bone Scan: _____

Flu vaccine: _____

Pneumonia vaccine: _____

SOCIAL HISTORY			
Martial Staus ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	**Tobacco Use** ☐ Never ☐ Quit_____years ago ☐ Smoker _____ ☐ cigarettes ☐ daily	**Alcohol Use** ☐ Never ☐ Quit_____years ago ☐ 1-3 drinks ☐ 4-6 drinks ☐ weekly ☐ > 6 drinks ☐ monthly	**Drug Use** ☐ None ☐ Quit_____years ago ☐ Marijuana ☐ Cocaine ☐ Other2
Occupation: _____		☐ Retired	☐ Disabled

FAMILY HISTORY					
Relatives	Alive Health	Died Cause	Age	Is there family history of	Residence-travel-activity
Father Mother Brothers Sisters Sons Daughters	☐ ☐ ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐	☐ ☐ ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐	_____ _____ _____ _____ _____ _____	☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Urinary stones ☐ Kidney disease ☐ Cancer	How long in AZ _____ Permanent resident _____ Home town/area _____ Foreign travel _____ Activities _____ Hobbiees _____

Patient Name: _____ Age: _____ Date: _____

I personally reviewed this form with the patient: _____

Mesa Urologists (IF YOU'RE A MAN...)

Take these tests to find out about 2 common conditions.

You may feel embarrased to talk to your doctor about urinary problems. But, like gray and thinning hair, such problems are a part of aging. One of the causes of urinary symptoms in men over 50 is a treataoic condition called benign prostatic hyperplasia (BPH). In fact, It has been estimated that by the age of 80, 1 in every 4 males in the US will require treatment of their urinary symptoms caused by BPH.
Take this quiz to help you and your doctor decide whether you could benefit from a BPH treatment.

TAKING THE QUIZ (Please circle the answer that best represents your response to each of the following questions. The questions are designed to gauge the severity of any symptoms you may be experiencing.)

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
1. 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	_____
2. 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	_____
3. 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	_____
4. URGENCY (Over the past month, how often have you found it difficult to postpone urination?)						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
5. WEAK STREAM (Over the past month, how often have you had a weak urinary stream?)						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
6. STRAINING (Over the past month, how often have you had to push or strain to begin urination?)						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
7. NOCTURIA (Over the past 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?)						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
					Your Total Score	_____
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?)						
Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

Adapted from Barry MJ. et al. The American Urological Association symptom index for benign prostatic hyperplasia. J Urol. 1992:148:1549-1557.

SCORING THE QUIZ: Add the numbers from your answers to questions 1 through 7. The maximum possible score is 35. The final question will help you judge how you feel about your symptoms.

PLEASE NOTE: This test is used to measure the severily of your symptoms. It is not a diagnostic test. In other words, it will not tell you whether or not you have BPH. Talk to your doctor to determine whether your symptoms are due to BPH.

Remember: This information is not intended as a substitute for medical treatment.

Patient: _____ Date _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○ 0	○ 1	○ 2	○ 3
2. Feeling down, depressed, or hopeless	○ 0	○ 1	○ 2	○ 3
3. Trouble falling or staying asleep, or sleeping too much	○ 0	○ 1	○ 2	○ 3
4. Feeling tired or having little energy	○ 0	○ 1	○ 2	○ 3
5. Poor appetite or overeating	○ 0	○ 1	○ 2	○ 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	○ 0	○ 1	○ 2	○ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	○ 0	○ 1	○ 2	○ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	○ 0	○ 1	○ 2	○ 3
9. Thoughts that you would be better off dead, or of hurting yourself	○ 0	○ 1	○ 2	○ 3
add columns		_____+	_____+	_____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all _____
	Somewhat difficult _____
	Very difficult _____
	Extremely difficult _____