NOTICE

Please **complete** the enclosed forms and **BRING** them with you to your scheduled appointment.

Though you may have filled out similar forms with our other site, we will still need you to completely fill these out as well.

The Oregon Urology Institute has a relationship with you, our patient, and not insurance companies. We will bill your insurance company for services provided as a courtesy and will do our best to help you understand the coverage your insurance company provides. However, it is important for you to understand that most insurance products will not cover all of our charges and will probably require you to make some type of payment. For your convenience we accept cash, checks, debit cards, Visa, MasterCard and Discover.

Co-payments, Co-insurance and deductibles are due at the time of service and vary by insurance product and by service provided. A deposit of $100 is expected at time of service for **uninsured** patients.

Any financial questions can be answered by our Patient Financial Coordinator.

Referrals and/or Prior Authorization may be required by your insurance company. While we attempt to obtain these, it is your responsibility to make sure they are in place prior to your appointment, according to your insurance guidelines. If a referral is required and not in place at the time of your appointment you may be required to sign a waiver stating acceptance of responsibility for the unauthorized service.

PLEASE BRING YOUR INSURANCE CARDS TO YOUR APPOINTMENT.

If you have further questions please call our office at the number below.

A map is provided on the back of this sheet for our Radiation Center location.

ADVANCED ONCOLOGY

Advanced Oncology/Oregon Urology Institute P.C.
1457 G. Street
Springfield, OR 97477
Phone: (541) 334-3351
Fax: (541) 334-4478

NEW PATIENT QUESTIONNAIRE

Advanced Oncology/Oregon Urology Institute P.C.

1457 G Street, Springfield OR 97477 541-334-3351

Name DOB Today's Date

Diagnosis Referring Physician Primary Care Physician

Reason for Today's Visit (In Your Own Words) e-mail address

Preferred Method for Receiving Reminders: E-mail ☐ Cell Phone ☐

Current Medications

Medication	Dose / Frequency

Medication	Dose / Frequency

Preferred Pharmacy:_____

Preferred Laboratory:_____

Allergies to Medications (List all including description of reaction):

_____

_____

Date of your last Colonoscopy: _____

Are you at risk for falls:_____

Past Medical History (Please mark only if you have a history of any of the following):

	Lupus
	Scleroderma
	Collagen Vascular Disease
	Urinary Retention /Catheterization
	Implanted Pacemaker /Defibrillator
	Sarcoid
	Diabetes
	Mental Health Issues
	Abnormal Heart Rhythm
	Alzheimer's
	Anemia

	Asthma
	Atrial Fibrillation (AFib)
	Autoimmune Disorder
	Bipolar Disease
	Bladder Cancer
	Bleeding Disorder
	Brain Tumor
	Breast Cancer
	Cervical Cancer
	Cirrhosis
	Clotting Disorder
	Colon Cancer
	Congestive Heart Failure (CHF)

	COPD (Chronic Obstructive Pulmonary Disease)
	Coronary Artery Disease
	Crohn's Disease / Ulcerative Colitis (UC)
	Dementia
	Depression
	Diabetes – Type 1 (juvenile)
	Diabetes – Type 2 (adult)
	Dialysis
	Diverticulitis / Diverticulosis
	DVT (Deep Vein Thrombosis, ie blood clots)
	Endometriosis

	Fibromyalgia
	GERD (Heartburn, Gastro-Esophageal Reflux Disease)
	Glaucoma
	Head & Neck Cancer
	Heart Attack (MI, or Myocardial Infarct)
	Hepatitis
	High Blood Pressure (Hypertension, HTN)
	High Cholesterol (Hyperlipidemia)
	Hypothyroidism
	Incontinence
	Infertility
	Irritable Bowel Syndrome (IBS)

	Kidney Cancer
	Kidney Disease
	Kidney Stones
	Leukemia
	Liver Disease
	Lung Cancer
	Lymphoma
	Multiple Sclerosis (MS)
	Myeloma
	Neurologic Disorder
	Osteoarthritis
	Osteoporosis
	Ovarian Cancer
	Pancreatitis
	Parkinson's Disease
	Peripheral Vascular Disease
	Pneumonia

	Prostate Cancer
	Pulmonary Embolism (PE)
	Rheumatoid Arthritis (RA)
	Schizophrenia
	Seizure
	Obstructive Sleep Apnea (OSA)
	Spinal Cord Injury
	Stroke (Cerebral Vascular Accident, CVA)
	TIA (Transient Ischemic Attack)
	Thyroid Cancer
	Gastrointestinal Bleeding (ulcer)
	Urinary Tract Infection (UTI)
	Valvular Heart Disease

Past Surgical History (Please mark only if you have a history of any of the following):

	Prostatectomy
	TURP (Trans-Urethral Resection of the Prostate)
	Nephrectomy (Removal of Kidney)
	Orchiectomy (Removal of Testicle)
	Abdominoplasty / 'Tummy Tuck'
	Amputation
	Aneurysm Repair
	Angioplasty
	Antireflux Surgery
	Aortic Bypass
	Appendectomy (Removal of Appendix)
	Arthroscopy
	AV Fistula
	Back Surgery

	Bladder Surgery
	Bowel Surgery
	Bowel Obstruction
	Brain Surgery
	Breast Augmentation
	Breast Reduction
	Bronchoscopy
	Carotid Endarterectomy
	Carpal Tunnel
	Coronary Stent / Heart Catheterization
	C-Section
	Defibrillator
	Dialysis Catheter
	Ear Tubes
	Exploratory Laparotomy / Laparoscopy
	Gall Bladder Removal (Cholecystectomy)
	Hernia Repair
	Hip Replacement

	Hysterectomy
	Hysterectomy with Oophorectomy (Ovaries also removed)
	Incontinence Surgery
	Knee Replacement Surgery
	Laminectomy
	Liposuction
	Lumpectomy
	Lung Surgery
	Mastectomy
	Neck Surgery
	Pacemaker
	Peripheral Arterial Bypass
	Repair of Fracture
	Shoulder Surgery
	Spinal Fusion
	Stomach Surgery
	Thyroid Surgery
	Tonsils

Family History:

Family Member	Medical Problem(s)
Father	
Mother	
Maternal Grandmother	
Paternal Grandmother	

Maternal Grandfather	
Paternal Grandfather	
Siblings	
Brother/Sister	
Brother/Sister	

Social History:

Smoking History:

	Current Smoker
	Former Smoker
	Never Smoker

# Years Smoked	
# Packs / Day	
# Years Quit	

Alcohol History

	Every Day
	Occasionally
	Quit / Former Drinker
	Never

# Days / Week	
# Drinks / Day	
# Years Quit	

Substance Use:

	Cigars
	Chewing tobacco
	Beer
	Illicit or recreational drugs
	Narcotics
	Marijuana
	Liquor
	Pipe smoking
	Cigarettes
	Wine
	Snuff

Occupational Exposures:

	Coal
	Benzene
	Asbestos
	Lead
	Mercury
	Red Dye #3
	Radiation
	Other Petroleum Products
	Xylene
	Agent Orange

Personal / Environment

Support Systems

	Single
	Married
	Significant Other
	Divorced
	Widowed
	Live with spouse/significant other, family or friends
	Live alone
	Live in Assisted Living environment
	Live in Nursing Home
	Homeless
	Incarcerated
	No Transportation Difficulties
	Will Need Transportation Assistance
	Family/Friends willing to assist with needs
	No support system in place
	Require Social Services for assistance

Activities

	Employed – Full Time
	Employed – Part Time
	Unemployed
	Disabled
	Retired
	Sedentary
	Light Exercise
	Occasional Exercise
	Regular Exercise
	Extensive Exercise
	Sexually Active
	Sexually Inactive

Nutrition

	Regular meals
	Nutritional Supplements
	Vegetarian
	Liquid Diet
	Diabetic Diet

Review of Systems:

General/Constitutional

	Decreased appetite
	Fatigue (physical)
	Fever
	Lethargy (mental)
	Night Sweats
	Rigors / Shaking Chills
	Weight Change (+/- 10% of normal weight)

Head & Neck

	Hair Loss (Alopecia)
	Blurry Vision
	Double Vision
	Watery Eyes (Lacrimation)
	Visual Light Sensitivity (Photophobia)
	Visual Difficulties
	Difficulty Swallowing (Dysphagia)
	Epistaxis (Nose bleeds)
	Esophagitis (Pain on Swallowing)
	Difficulty Hearing
	Dry Mouth
	Oral Bleeding
	Ear Pain (Otalgia)
	Sinusitis
	Mouth Sores (Stomatitis)
	Altered Taste
	Ringing in Ears (Tinnitus)
	Neck Masses/Lumps
	Neck Muscle Weakness
	Neck Pain
	Decreased Range of Motion in Neck
	Neck Swelling

Cardiovascular

	Irregular Heart Beat (Arrhythmia)
	Chest Pain
	Swelling of Legs (Edema)
	Shortness of Breath when Lying Down(Orthopnea)
	Palpitations

Respiratory

	Cough
	Shortness of Breath (Dyspnea)
	Coughing up Blood (Hemoptysis)
	Sharp Pain with Breathing
	Wheezing

Gastrointestinal

	Abdominal Pain
	Change in Bowel Habits
	Bright Red Blood in Stool
	Constipation
	Dark Blood in Stool / GI Bleeding
	Diarrhea
	Heartburn / reflux / GERD
	Hemorrhoids
	Nausea
	Early Satiety (Can't eat much in one sitting)
	Vomiting
	Vomiting Blood

Genitourinary

	Blood in Urine
	Increased Urinary Frequency
	Impotence
	Incontinence
	Nighttime Urination (Nocturia)
	Pain with Urination (Dysuria)
	Scrotal Swelling
	Urinary Urgency
	Urine Color Change
	Vaginal Bleeding / Discharge
	Vaginal Spotting

Musculoskeletal

	Arthritis
	Bone Pain
	Joint Pain
	Muscle Weakness
	Decreased Range of Motion

Neurologic

	Dizziness
	Gait / Walking Difficulty
	Headaches
	Difficulty Sleeping (Insomnia)
	Memory Difficulties
	Muscle Control (Motor Neuropathy)
	Paralysis
	Seizure
	Sensory Problems
	Stroke

Endocrine

	Diabetes
	Hot Flashes
	Menstrual Irregularities
	Thyroid Disease

Hematologic/Lymphatic

	Easy Bruising
	Swollen Lymph Nodes

Allergies/Immunologic

	Allergies
	Reactions

Skin (Integument)

	Hair Loss (Alopecia)
	Bruising
	Itchiness (Pruritus)
	Rash
	Hives

Breasts

	Breast Masses / Lumps
	Nipple Discharge
	Nipple Inversion
	Breast Pain

Psychiatric

	Hallucinations
	Depression
	Euphoria
	Mood Swings

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International Prostate Symptom Score

Name: _____ **Date:** _____

	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
Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urination?	0	1	2	3	4	5
Frequency Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
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
Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

	None	1 Time	2 Times	3 Times	4 Times	5 or more times
Nocturia Over the past month, how many times did you typically get up to urinate from the time you went to bed until you got up in the morning?	0	1	2	3	4	5
Add together the numbers above for the Total I-PSS Score						

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your current urinary condition, how would you feel about that?	0	1	2	3	4	5	6

Sexual Health Inventory for Men (SHIM)

Patient Name:_____ Today's Date: _____

Instructions: Please read carefully and circle a number that best describes your own situation. Be sure to only select one response in each group. All answers are strictly confidential and all data will be treated anonymously. This report will not be a part of your permanent medical record.

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual activity	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, how often was it satisfactory for you?

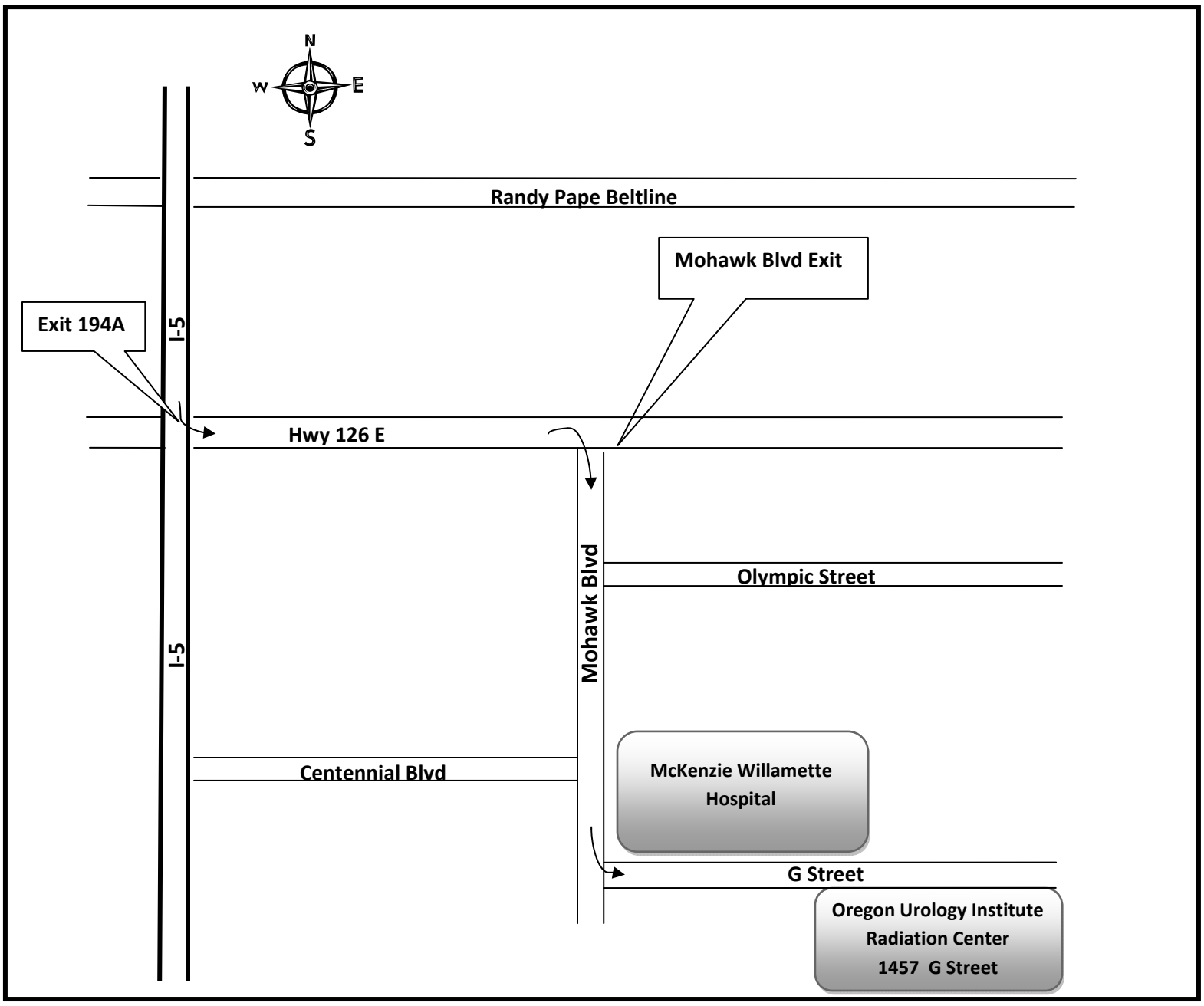
Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

Add the numbers corresponding to questions 1-5.	Total Score	

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED 8-11 Moderate ED 12-16 Mild to Moderate ED 17-21 Mild ED

Directions to Oregon Urology Institute's Radiation Center



Directions

From I-5 North & I-5 South

1- Take Exit 194A merge onto Hwy 126 E
2- Take the Mohawk Blvd Exit
3- Turn left at G Street
4- The Radiation Center is on your right at
1457 G Street, across from McKenzie Willamette Hospital

From Hwy 126

1- Take the Mohawk Blvd Exit
2- Turn left at G Street
3- The Radiation Center is on your right at
1457 G Street, across from McKenzie Willamette Hospital