**Please list the problems you would like evaluated today: (circle what bothers you most)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**How long has *THIS* problem been going on?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been evaluated for *THIS* problem before today’s visit?** □ No □ Yes (*If yes, by* ***whom****?* *Check all that apply)*□ Colorectal Surgeon □ Gastroenterologist □Gynecologist □ Urogynecologist □ Urologist
□ Other specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Diagnostic Studies**

*(Please check all applicable)*

□ Defecography □ Anorectal manometry □ Cystoscopy (look in the bladder with scope)

□ Kidney ultrasound or CT □ Barium enema □ Urodynamic test (bladder function test with catheter)

□ Pelvic ultrasound or MRI □ Colonoscopy □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Past Medical History**

**Please check all that apply, now or in the past.** □ I have no medical problems□ Anxiety □ Dementia (i.e. Alzheimer’s) □ Heart Valve/Rhythm Problem □ Liver Disease

□ Asthma □ Depression □ High Blood Pressure □ Neurologic Disease

□ Blood Clots □ Diabetes □ Immune Disorder (*specify*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Cancer (*specify*) \_\_\_\_\_\_\_\_\_ □ Gastrointestinal Ulcers □ Kidney Failure □ Psychiatric Disease

□ COPD □ Heart Attack/Chest Pain □ Kidney Stones □ Stroke/TIA

□ Other significant medical problems, hospitalizations, or trauma (*specify*): □ Thyroid Disease

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**List of Current Medication Allergies**

□ No medication allergies □ Yes, but I reviewed list on MyHealth □ Yes, I have medication allergies (*please list below*)

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**List of Current Medications**

Patient Label

(*Attach list if available)*

Complete **only** if you are a new patient to Stanford Health Care.□ No Medications □ I reviewed my medication list on MyHealth
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Surgical History**

□ I have had no surgeries

**Operation Month/Year Reason for Surgery**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Family History**

**(i.e. Cancer, Frequent UTIs, Kidney Stones, Prolapse, or Heart Attack before age 60?** *(please specify below)*□ I have no family history of medical problems
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History**

**Do you use any tobacco?** (*Check all that apply*)
□ Never smoked □ No, I quit When? \_\_\_\_\_\_\_\_ #packs/day? \_\_\_\_\_\_\_\_ How many years (estimate)? \_\_\_\_\_\_\_\_\_
□ Yes, I smoke tobacco \_\_\_\_\_\_\_\_ #packs/day? \_\_\_\_\_\_\_\_ How many years (estimate)? \_\_\_\_\_\_\_\_\_

**Do you drink alcohol?** □ Yes □ No *If yes, how many drinks per week/month/year*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use recreational drugs?** (i.e. marijuana, cocaine, heroin, methamphetamines, etc.) □ Yes □ No

*If yes, please answer the following questions*: What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital status**: □ Single □ Married □ Divorced □ Widowed □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation**: (current or most recent) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been sexually abused, threatened, or hurt by anyone?** □ Yes, in the past □ Yes, currently □ No

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**Gastrointestinal History**

Patient Label

During the past 12 months, what do your bowel movements usually

look like *when you are not taking laxatives*? (**please circle**)

 

**Do you have rectal bleeding?** □ Yes □ No

**During a typical 2-week period, how many times do you usually have a bowel movement?**

\_\_\_\_\_\_ 1 or more/day

\_\_\_\_\_\_ 2 or fewer times/day

\_\_\_\_\_\_ Less than once/week

\_\_\_\_\_\_ Less than once/2 weeks

**Please complete if you have any bowel problems** (*Otherwise, skip to* ***page 4***)

**Accidental Bowel Leakage: Unable to control the bowel**For each of the following, please indicate on average how often **in the past month** you experienced any amount of **accidental bowel leakage**: *(Check only 1 box per row)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Less than once a month | Greater than once a month and less than once a week | Greater than once a week and less than daily | Daily or several times a day |
| Gas |  |  |  |  |  |
| Liquid Stool |  |  |  |  |  |
| Solid Stool |  |  |  |  |  |
| Do you wear a pad? |  |  |  |  |  |
| Does bowel leakage impact your quality of life? |  |  |  |  |  |

**Difficult Evacuation: Difficulty emptying the bowels**

Do you have difficulty emptying the bowels? (*Check only 1 box per row*)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Rarely | Sometimes | Usually | Always |
| Excessive Straining |  |  |  |  |  |
| Incomplete rectal sensation |  |  |  |  |  |
| Use of enema/laxatives  |  |  |  |  |  |
| Do you need to use a finger to help evacuate stool |  |  |  |  |  |
| Abdominal discomfort /pain |  |  |  |  |  |

**Urinary History**

Patient Label

**Please complete if you have any urinary problems**(*Otherwise, skip to* ***page 6***)

**Do you drink any of the following fluids?**(*please check all that apply and give your best estimate*)
□ Caffeine (i.e. coffee, tea, soda, energy drinks) How many cups/day: \_\_\_\_\_\_\_\_\_\_\_\_\_
□ Carbonated fluids (i.e. sparkling water, caffeine free soda) How many cups/day: \_\_\_\_\_\_\_\_\_\_\_\_\_
□ Water (uncarbonated) How many cups/day: \_\_\_\_\_\_\_\_\_\_\_\_\_
□ Other (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many cups/day: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take any medications for an overactive bladder?** □ Yes □ Yes, but I stopped taking it □ No

*CIRCLE all that apply*: Oxybutynin, Trospium, Detrol, Vesicare, Mirabegron, Enablex, Toviaz
*Other*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you go to the bathroom to urinate too frequently?** □ Yes □ Yes, but it doesn’t bother me □ No
*If yes, how frequently* (i.e. every 1, 2, 3 hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   *How many times during the day*? \_\_\_\_\_\_\_\_\_

**Do you get sudden urges to urinate and have to drop everything and run?** □ Yes □ Yes, it doesn’t bother me □ No
*If yes, how frequently does this happen* (circle one): **rarely daily weekly monthly other**: \_\_\_\_\_\_\_\_\_­

**Do you leak because you can’t make it to the bathroom?** □ Yes □ Yes, but it doesn’t bother me □ No
*If yes, how frequently does this happen* (circle one): **rarely daily weekly monthly other**: \_\_\_\_\_\_\_\_\_­

**Do you leak when you cough, sneeze, laugh, or exercise?** □ Yes □ Yes, but it doesn’t bother me □ No
*If yes, how frequently does this happen* (circle one): **rarely daily weekly monthly other**: \_\_\_\_\_\_\_\_\_­

**Do you wear pads (or diapers) for urinary leakage?** □ Yes □ Yes, but it doesn’t bother me □ No
 *If yes, how many per day*? \_\_\_\_\_\_\_\_\_

**Do you get up at night to urinate (nocturia)?** □ Yes □ Yes, but it doesn’t bother me □ No
 *If yes, how many times per night*? \_\_\_\_\_\_

**Do you leak or wet the bed while sleeping at night?** □ Yes □ No

*If yes, how frequently does this happen* (circle one): **rarely daily weekly monthly other**: \_\_\_\_\_\_\_\_\_­

**Do you have difficulty emptying your bladder?**  □ Yes □ No

Patient Label

**Do you have any of the following?** (*If yes, please check all that apply*) □ Burning with urination □ Visible blood in urine □ No, I do not experience any of these

**Do you have recurrent urinary tract infections (UTIs)?** □ Yes □ No

(*If yes, please answer the following questions, otherwise skip to next page*)

How *OFTEN* do you get UTIs (how many per year)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has this been a problem (how many months or years)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all that apply**:

□ I get urine cultures sometimes □ I always get urine cultures, they are usually positive

□ I just get antibiotics when I have UTI symptoms □ I always get urine cultures, they are usually negative

What are your UTI symptoms (please list all)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your UTI triggers (i.e. sexual activity)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your UTIs better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Proceed to next page)**

Patient Label

**Gynecological History**

**Please complete if you are FEMALE**(*Otherwise, skip to* ***next page***)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes | No | Sometimes | Sometimes, but it doesn’t bother me | N/A |
| Are you sexually active? |  |  |  |  |  |
| Do you have pain with sex? |  |  |  |  |  |
| Do you have abnormal vaginal bleeding?(Bleeding between periods or after menopause) |  |  |  |  |  |
| Do you feel a bulge or pressure in the vagina? |  |  |  |  |  |

**Number of pregnancies** \_\_\_\_\_ Number of vaginal deliveries \_\_\_\_\_ Number of C-sections \_\_\_\_\_
Were forceps or a vacuum used for any of your deliveries? □ Yes □ No □ Not applicable

 **When was your last menstrual period** (or age at your last period)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*Note: If you are post-menopause or hysterectomy (uterus removed), please give estimated age at last menstrual period.***Are your periods regular?** □ Yes □ No □ Not applicable (i.e. menopause, hysterectomy,)

**Are you currently on any of the following?**  □ No  □ Yes (*If yes, please check all that apply)*
□ Cranberry pills □ Birth control pills/patch/ring/shots □ IUD (Mirena or copper)
□ Low dose antibiotics □ Vaginal estrogen (i.e. Premarin, Vagifem, Estrace, or Estring)
□ Probiotics □ Hormone replacement pills/patch (i.e. estrogen, progesterone)

**Have you had a Pap smear?** □ Yes, all tests have been negative □ Yes, I have had abnormal test(s) □ No, never *If yes, when was your last Pap smear (year)*? \_\_\_\_\_\_\_\_\_\_\_\_

**Have you had treatment for prolapse or incontinence?**  □ Yes □ No *If yes, check* *all that apply*:
□ Pessary □ Physical Therapy □ Prolapse Surgery □ Incontinence Surgery □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Label

**Please complete if you are MALE**

(*Otherwise, skip to* ***next page***)

**Do you have difficulty emptying your bladder?** □ No □ Yes (*If yes, please check all that apply)*
□ I feel that my bladder never or rarely gets empty □ I have a weak stream all or most of the time
□ I have to go back to the bathroom right after urinating □ I always have to strain to urinate
□ I drip after I am finished urinating and walk away □ It takes a while to get started
□ I've had to get a catheter before because I couldn't urinate □ My stream is stop and go
□ I had surgery to treat a urethral stricture (i.e. dilation, laser etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have problems with erections?** □ No □ Yes

*If yes, have you tried medications in the past*? □ Yes □ No □ No, but I would like to try one

**Do you currently take any of the following medications?**□ No □ Yes □ Yes, in the past, but I stopped taking it *If* yes*, please check all that apply* □ Tamsulosin (Flomax) □ Dutasteride (Avodart) □ Viagra□ Alfuzosin (Uroxatral) □ Proscar (Finasteride) □ Cialis□ Terazosin (Hytrin) □ Dutasteride/Tamsulosin (Jalyn) □ Levitra□ Doxazosin(Cardura) □ Testosterone replacement therapy □ Staxyn□ Sildosin (Rapaflo) □ Other prostate/male health medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had a Prostate Specific Antigen (PSA – prostate cancer screening test)?**□ Yes, all have been normal □ Yes, they have been elevated □ No, never*If yes, what was your last score* (estimate is okay)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (month/year) **Do any of the following apply to you?** □ No □ Yes (*If yes, please check all that apply)*
□ Surgery to treat an enlarged prostate (i.e. TURP- Transurethral resection of prostate)
□ Prostate biopsy

□ Family history of prostate cancer
□ Personal history of prostate cancer (*If yes, what treatment did you receive*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**(Proceed to next page)**

Patient Label

**Current Review of Systems**

Have you had any problems **in this past year**? Check Yes or No and *explain Yes answers*.

(Patients will be writing their comments on the form)

PATIENT COMMENTS

|  |  |  |
| --- | --- | --- |
| Allergic/Immunologic(rashes/infections/etc.) | □ Yes □ No |  |
| Constitutional(general health, weight, energy) | □ Yes □ No |  |
| Cardiovascular(heart/blood vessels/circulation) | □ Yes □ No |  |
| Eyes(any visual problems) | □ Yes □ No |  |
| Ears/Nose/Mouth/Throat(hearing/infections/congestion/pain) | □ Yes □ No |  |
| Endocrine(hormones/metabolism/thyroid) | □ Yes □ No |  |
| Gastrointestinal(stomach/intestines/bowel movements) | □ Yes □ No |  |
| Hematologic/Lymphatic(bleeding/lymph nodes/swollen glands) | □ Yes □ No |  |
| Musculoskeletal(bones/joints/muscles) | □ Yes □ No |  |
| Neurological(brain/nervous system) | □ Yes □ No |  |
| Psychiatric(emotions/mood/memory) | □ Yes □ No |  |
| Respiratory(lungs/breathing) | □ Yes □ No |  |
| Integumentary(skin lesions/breast lumps) | □ Yes □ No |  |
| Genitourinary(genitals/sexual function/kidneys/bladder) | □ Yes □ No |  |

***\*\*\* By signing below, you are verifying that this form was completed to the best of your ability and knowledge.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE TIME SIGNATURE (Patient or Properly Designated Representative)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME RELATIONSHIP TO PATIENT

Patient Label

**FOR OFFICE USE ONLY
PROVIDER DOCUMENTATION**

**Instructions to Attending Physician:**

**Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however, the questionnaire may be referenced for additional details.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending Physician Signature Print Name Date Time

The preceding information was also reviewed by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE TIME Provider Signature/Title Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE TIME Provider Signature/Title Print Name

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DATE TIME Provider Signature/Title Print Name

Copy: Patient □ Declined □ Received