



Rocklin Family Practice & Sports Medicine

Roy Harris, M.D. • Kuo Ooi, M.D. • Biljinder Chima, M.D.

Patient Name: _____ Sex: M F Date of Birth: _____
First Middle Last

Social Security: _____ Email Address: _____

Race: _____ Ethnicity: Hispanic Non-Hispanic Decline to State Preferred Language: _____

Mailing Address: _____ City _____ State _____ Zip _____

Home Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Employer: _____ Occupation: _____

Employer Address: _____ City _____ State _____ Zip _____

Spouse's Name: _____ Social Security: _____ DOB: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Immediate family members living with you: _____

EMERGENCY CONTACT

Nearest relative not living with you: _____ Relation: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

RESPONSIBLE PARTY – If patient is a minor please name parent or guardian

Name: _____ Social Security: _____ DOB: _____
(Use name of legally responsible person)

Mailing Address: _____ City _____ Zip _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

MEDICAL INSURANCE

WE BILL INSURANCE COMPANIES WITH WHICH ROY M. HARRIS M.D., INC. IS CONTRACTED, OTHER WISE PAYMENT IS DUE AT THE TIME OF SERVICE.

Insurance Company: _____ Subscriber's Name: _____

I.D. #: _____ Group #: _____ Subscriber's DOB: _____

PATIENT OR AUTHORIZED PERSON SIGNATURE - Read and initial each statement

- ____ I authorize all medical treatment as deemed necessary by Roy M. Harris M.D., Inc. and affiliated providers.
- ____ I authorize release of any medical or other information necessary to process claims.
- ____ I authorize my insurance carrier to make payment directly to Roy M. Harris M.D., Inc. for any medical services rendered.
- ____ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.
- ____ I understand I may be charged **\$25.00** if I do not show for an appointment or give less than a 24-hour notice to cancel or reschedule.
- ____ I have received and read the "Advance Directives" and "HIPPA" Notice of Privacy Practices.
- ____ I give permission for the staff to leave a message when calling to confirm appointments.

Signature X _____ Date: _____

Patient Questionnaire

NAME: _____ SEX Male Female AGE: _____ TODAY'S DATE _____

MARITAL STATUS

- Married
- Widowed
- Separated
- Divorced
- Never married

YOUR BACKGROUND

- Black (not Hispanic)
- Hispanic
- White (not Hispanic)
- Asian
- Other- describe: _____

HOW FAR YOU WENT IN SCHOOL

- 8th grade or less
- Some high school
- High school graduate or equivalency (GED)
- Some college or associate degree
- Completed college

INSTRUCTIONS: This questionnaire will help your doctor better understand problems that you may have. Your doctor may ask you more questions about some of these items. Please make sure to check a box for every item that applies.

During the PAST MONTH, have you OFTEN been bothered by...			During the PAST MONTH...					
	YES	NO		YES	NO		YES	NO
1. stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any:	<input type="checkbox"/>	<input type="checkbox"/>	22. have you had an anxiety attack (suddenly feeling fear or panic)	<input type="checkbox"/>	<input type="checkbox"/>
2. back pain	<input type="checkbox"/>	<input type="checkbox"/>	• constipation	<input type="checkbox"/>	<input type="checkbox"/>			
			• diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
3. pain in your	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any:	<input type="checkbox"/>	<input type="checkbox"/>	23. have you thought you should cut down on your drinking of alcohol	<input type="checkbox"/>	<input type="checkbox"/>
• arms	<input type="checkbox"/>	<input type="checkbox"/>	• nausea	<input type="checkbox"/>	<input type="checkbox"/>			
• legs	<input type="checkbox"/>	<input type="checkbox"/>	• gas	<input type="checkbox"/>	<input type="checkbox"/>			
• joints	<input type="checkbox"/>	<input type="checkbox"/>	• indigestion	<input type="checkbox"/>	<input type="checkbox"/>	24. has anyone complained about your drinking	<input type="checkbox"/>	<input type="checkbox"/>
• knees	<input type="checkbox"/>	<input type="checkbox"/>	14. feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>			
• hips	<input type="checkbox"/>	<input type="checkbox"/>	15. trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	25. have you felt guilty or upset about your drinking	<input type="checkbox"/>	<input type="checkbox"/>
• other	<input type="checkbox"/>	<input type="checkbox"/>	16. the thought that you have a serious undiagnosed disease	<input type="checkbox"/>	<input type="checkbox"/>			
4. menstrual pain or problems	<input type="checkbox"/>	<input type="checkbox"/>	17. your eating being out of control	<input type="checkbox"/>	<input type="checkbox"/>	26. was there ever a single day in which you had five or more drinks of beer, wine, or liquor	<input type="checkbox"/>	<input type="checkbox"/>
5. pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	18. little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	Overall would you say your health is:		
6. headaches	<input type="checkbox"/>	<input type="checkbox"/>	19. feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	
7. chest pain	<input type="checkbox"/>	<input type="checkbox"/>	20. "nerves" or feeling anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	Very good	<input type="checkbox"/>	
8. dizziness	<input type="checkbox"/>	<input type="checkbox"/>	21. worrying about a lot of different things	<input type="checkbox"/>	<input type="checkbox"/>	Good	<input type="checkbox"/>	
9. fainting spells	<input type="checkbox"/>	<input type="checkbox"/>				Fair	<input type="checkbox"/>	
10. feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>				Poor	<input type="checkbox"/>	
11. shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>						

Take this test if you are a man age 40 or older

You may feel embarrassed to talk to your doctor about urinary problems. But, like gray and thinning hair, such problems are part of again for many men. A benign, treatable condition called benign prostatic hyperplasia (BPH) causes urinary symptoms for a quarter of men over the age of 50 and 40% of men over the age of 60.

Take this quiz to help you and your doctor decide whether you need treatment for BPH.

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	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+	
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?	0	1	2	3	4	5	6

Adapted from Barry MJ et al: The American Urological Association symptoms index for benign prostatic hyperplasia. J Urol 1992;148(5):1549-57

Scoring the Quiz

Add the numbers from your answers to questions 1-7. 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 severity of your symptoms. It is not a diagnostic test. In other words, it will not tell you whether or not you have BPH. Talk with your doctor to determine whether your symptoms are due to BPH.