REGISTRATION RECORD

PLEASE PRINT THE FOLLOWING INFORMATION. IF YOU NEED ASSISTANCE IN FILLING OUT THIS FORM, PLEASE ASK FOR HELP.

TODAY'S DATE _____

PATIENT'S NAME M F S M D W
First Middle Last Sex Marital Status

PATIENT'S ADDRESS
Number and Street City, State Zip

PATIENT'S PHONE ( ) SOC. SECURITY # - - DATE OF BIRTH

MESSAGE PHONE ( ) E-MAIL

EMPLOYER OF PATIENT

EMPLOYER'S ADDRESS
Number and Street City, State Zip

EMPLOYER'S PHONE ( ) **REFERRING PHYSICIAN**

RESPONSIBLE PARTY
Name Address City, State Zip

RESPONSIBLE PARTY'S PHONE ( ) S.S.# - - EMPLOYER

RESPONSIBLE PARTY'S EMPLOYER PHONE ( ) ADDRESS

NAME OF INSURANCE COMPANY

ADDRESS OF INSURANCE CO.
Number and Street City, State Zip

NAME OF INSURED PERSON

INSURED PERSON'S DATE OF BIRTH INSURED PERSON'S S.S.# - -

GROUP & POLICY NUMBER

NAME OF 2ND INSURANCE COMPANY (IF APPLICABLE)

ADDRESS OF 2ND INSURANCE CO.
Number and Street City, State Zip

NAME OF INSURED PERSON (2ND INSURANCE)

INSURED PERSON'S DATE OF BIRTH (2ND INSURANCE) INSURED PERSON'S S.S.# - -

GROUP & POLICY NUMBER (2ND INSURANCE)

PLEASE PRESENT ANY COMPLETED INSURANCE FORMS OR CARDS AVAILABLE

PERSON TO CONTACT IN CASE OF EMERGENCY

TELEPHONE NUMBER ( ) RELATIONSHIP

ADDRESS
Number and Street City, State Zip

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM AND REQUEST THAT PAYMENT OF ALL BENEFITS BE MADE TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED BENEFITS AND ALL DEDUCTIBLES NOT COVERED BY THIS AUTORIZATION. SHOULD THE ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, THE UNDERSIGNED SHALL PAY ACTUAL ATTORNEY'S FEES AND COLLECTION EXPENSES.

SIGNED (INSURED OR AUTHORIZED PERSON) _____ _____ DATE _____

IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES, INCLUDING PHONE NUMBER CHANGES. PLEASE RETURN THIS FORM TO THE RECEPTIONIST. THANK YOU FOR YOUR ASSISTANCE.

Salman S. Razi MD Inc.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Salman S. Razi MD Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Salman S. Razi MD Inc.'s Notice of Privacy provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy prior to signing this consent. Salman S. Razi MD Inc. reserves the right to revise its Notice of Privacy at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Salman S. Razi MD Inc. Privacy Official at 2160 W. Grantline Rd., Ste. 140, Tracy, CA, 95377.

With this consent, Salman S. Razi MD Inc. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Salman S. Razi MD Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked *Personal* and *Confidential*.

With this consent, Salman S. Razi MD Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that Salman S. Razi MD Inc. restrict how it issues or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Salman S. Razi MD Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Salman S. Razi MD Inc. may decline to provide treatment to me.

AUTHORIZATION FOR RELEASE OF
PATIENT INFORMATION OR TEST RESULTS

_____ **I give my permission for office staff of Salmon S. Razi MD Inc. to release results of completed tests (blood work, pathology, x-ray, specialty procedures), or general information to my spouse or** _____
_____
_____

_____ **I authorize office staff of Salman S. Razi MD Inc. to release information regarding lab reports, prescription information, or appointment information to my answering machine.**
(The patient must be identifiable with either name or phone number indicated in the message.)

_____ **I DO NOT authorize any information regarding my laboratory results, medical conditions, or appointment information to be given to any family member, including my spouse.**

_____ _____
Signature of Patient or Legal Guardian **Date**

_____
Patient's Name

_____/_____
Decline to Sign **Staff Initials**

_____
Staff Witness

Patient History Form

This is a confidential record and will be kept in your physician's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date _____ Date of Last Physical Exam _____

Last Name _____ First Name _____ Middle Name _____

Social Security # _____ Date of Birth _____

Chief Complaint (what is the main reason for your visit today?): _____

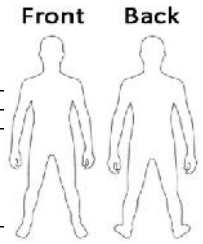
_____

_____

History of Present Illness

Please answer the following questions:

Location of the problem:
Abdomen Back Leg
Other_____
_____
_____



When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other_____

Does anything help or make the problem worse?
Moving around Standing up Lying on my side
Other_____
_____

How long does the problem last?
30 min. 1 hour Always there
Other_____

Is there anything else occurring at the same time?
Yes No If yes, please explain:
Nausea Rash Headaches
Other_____

Is the problem constant or variable?
Dull then sharp Very sharp, then disappears
Always there

Does the problem interfere with your normal functions?
Yes No If yes, please explain:
Other_____

Past Medical & Social History

List all serious illnesses in your immediate family (examples: diabetes, tuberculosis, cancer, heart disease, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

List any personal past illnesses and/or surgeries, and when they occurred.

Illness / Surgery	Date of Occurrence

Do you have any allergies? _____

Are you on any medications? Yes No (If yes, list all medications on the lines below.)

_____ _____ _____ _____

_____ _____ _____ _____

Do you smoke? Yes No If yes, how much? _____

Do you drink? Yes No If yes, how much? _____

Review of Systems

Do you now, or have you ever, had any problems related to the following systems? Circle Yes or No

Constitutional Systems

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other_____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Other_____

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other_____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other_____

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N

Other_____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N

Other_____

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other_____

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other_____

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other_____

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other_____

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Other_____

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Other_____

Hematological/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problem	Y	N

Other_____

Psychological

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N

Physician Signature:_____ Date:_____

THIS FORM IS FOR MALES

(Females should NOT complete this form.)

Low Testosterone Questionnaire

ADAM Questionnaire (Androgen Deficiency in the Aging Male)

If you are concerned that your testosterone level is low, this set of ten simple questions is a good place to start. You can save a copy of this form to your personal computer by clicking on the file menu on the top left of the page and then selecting "save as" or "save a copy".

	Answer YES or NO to each of the following questions:	**Yes**	**No**
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and/or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decreased "enjoyment of life?"		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		

If you answered YES to questions 1 or 7 or any 3 other questions, you may be experiencing androgen deficiency (low testosterone level). A simple saliva test done in the privacy of your home can help you determine your free testosterone level. To order a home-saliva testosterone test click the link below.

http://www.prostatehealthnaturally.com/prostate_supplements/prostate_supplements_other.html

***Adapted from Morley, et al. Validation of a screening questionnaire for androgen deficiency in aging males. Metabolism. 2000;49(9):1239-1242*

THIS FORM IS FOR MALES

(Females should NOT complete this form.)

International Prostate Symptom Score (I-PSS)

Patient Name: _____ **Date of birth:** _____ **Date completed** _____

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

THIS FORM IS FOR FEMALES

(Males should NOT complete this form.)

BLADDER SYMPTOM QUESTIONNAIRE

Name: _____ Date: _____

Doctor: _____

Which symptoms best describe what you're experiencing? Check all that apply:

- ☐ Frequent urination – day, night or both
- ☐ Sudden or strong urge to urinate
- ☐ Leakage with little or no warning – sometimes unable to make it to the bathroom in time
- ☐ Unable to completely empty bladder – feels like there is more even after going to the bathroom
- ☐ Accidental leakage with physical activity – exercising, sneezing or coughing
- ☐ Bladder or pelvic pain
- ☐ Problems with bowel function (if checked, please select symptom below):
  - ☐ Accidental loss or leakage of stool ☐ Constipation ☐ Other
- ☐ No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No

If yes, how many different medications have you tried? _____

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle a number:

0	1	2	3	4	5	6	7	8	9	10

NO RELIEF **COMPLETE SYMPTOM RELIEF**

Are you still taking any of these medications? ☐ Yes ☐ No

If no, why have you stopped taking them?

- ☐ Did not work as well as expected
- ☐ Side effects
- ☐ Expense
- ☐ Interaction with other medications
- ☐ Other

If SIDE EFFECTS or OTHER were checked above, please explain: _____

_____

Behavioral modifications tried? _____

(i.e., reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bladder control symptoms? Circle a number:

0	1	2	3	4	5	6	7	8	9	10

NOT FRUSTRATED **EXTREMELY FRUSTRATED**

Are you interested in learning more about additional treatment alternatives to bladder medications?

☐ Yes ☐ No