

REVIEW OF SYSTEMS

NAME:			PC3 #:			DATE:					
ALLERGIES			EYES								
DRUGS	Y	N	BLURRED VISION	Y	N						
ENVIRONMENTAL	Y	N	DOUBLE VISION	Y	N						
CARDIOVASCULAR			GLASSES	Y	N						
			READING GLASSES	Y	N						
IRREGULAR HEARTBEAT	Y	N	GI								
CHEST PAIN	Y	N	ABDOMINAL PAIN	Y	N						
SWELLING	Y	N	HEARTBURN	Y	N						
CONSTITUTIONAL			GENITOURINARY								
POOR APPETITE	Y	N									
FATIGUE	Y	N							PAINFUL URINATION	Y	N
FEVER	Y	N							FREQUENCY	Y	N
CHILLS	Y	N							BLOOD	Y	N
WEIGHT CHANGE	Y	N							URGENCY	Y	N
ENDOCRINE									INCONTINENCE	Y	N
DIABETES	Y	N	HEM/LYMPH								
THYROID PROBLEMS	Y	N	BLEED EASILY	Y	N						
ENMT			TENDER LYMPH NODES	Y	N						
TROUBLE SWALLOWING	Y	N	SKIN								
DIFFICULTY HEARING	Y	N									
HEARING AIDS	Y	N							BLISTERS	Y	N
SORE THROAT	Y	N							PERSISTENT ITCH	Y	N
SINUS PROBLEMS	Y	N							RASH	Y	N
MUSCULOSKELETAL									NEUROLOGICAL		
ARTHRITIS	Y	N	DIZZINESS	Y	N						
BONE PAIN	Y	N	BALANCE PROBLEMS	Y	N						
JOINT PAIN	Y	N	HEADACHE	Y	N						
BACK PAIN	Y	N	MEMORY LOSS	Y	N						
MUSCLE WEAKNESS	Y	N	TREMORS	Y	N						
RESPIRATORY			PSYCHIATRIC								
COUGH	Y	N									
SHORTNESS OF BREATH	Y	N							DEPRESSION	Y	N
WHEEZING	Y	N							ANXIETY	Y	N

PATIENT HISTORY FORM

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE _____

**MEDICAL PROBLEMS: DO YOU CURRENTLY HAVE OR HAVE HAD A HISTORY OF ANY OF THE FOLLOWING PROBLEMS?
PLEASE CHECK ALL THAT APPLY.**

ASTHMA	<input type="checkbox"/>	HIGH CHOLESTEROL	<input type="checkbox"/>
ATRIAL FIBRILLATION (A-FIB)	<input type="checkbox"/>	HYPERTENSION	<input type="checkbox"/>
CARDIOVASCULAR DISEASE	<input type="checkbox"/>	KIDNEY STONES	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	OSTEOARTHRITIS	<input type="checkbox"/>
EMPHYSEMA	<input type="checkbox"/>	OTHER CANCER(S)	<input type="checkbox"/>
GASTRIC REFLUX	<input type="checkbox"/>	RHEUMATOID ARTHRITIS	<input type="checkbox"/>
GLAUCOMA	<input type="checkbox"/>	SEIZURES	<input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	STROKE	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>
OTHER: _____			

SURGICAL PROCEDURES: PLEASE LIST ANY SURGERIES YOU HAVE HAD AND THE YEAR THEY WERE PERFORMED.

**FAMILY HISTORY: PLEASE LIST ANY HISTORY OF DIABETES, HEART DISEASE, OR CANCER IN YOUR FAMILY MEMBERS
(PLEASE INCLUDE RELATIONSHIP TO YOU -- i.e. FATHER, MOTHER, BROTHER, SISTER, ETC.)**

SOCIAL HISTORY:

DO YOU SMOKE? YES: NO: IF YOU ANSWERED YES, HOW MANY PACKS PER DAY DO YOU SMOKE? _____

DO YOU HAVE A HISTORY OF SMOKING? YES: NO:

AT WHAT AGE DID YOU START SMOKING? _____ WHEN DID YOU QUIT SMOKING? _____

IF YOU HAVE QUIT SMOKING, HOW MANY PACKS PER DAY WERE YOU SMOKING? _____

DO YOU DRINK ALCOHOL? _____ HOW MANY DAYS PER WEEK? _____ DRINKS PER DAY? _____

PATIENT HISTORY FORM CONTINUED

PLEASE LIST DATES FOR THE APPLICABLE SCREENING TESTS:

MOST RECENT COLONOSCOPY: _____

RESULTS OF COLONOSCOPY: CIRCLE ONE: NEGATIVE or POSITIVE for COLON CANCER _____

MOST RECENT MAMMOGRAM: _____

RESULTS OF RECENT MAMMOGRAM: CIRCLE ONE: NEGATIVE or POSITIVE for BREAST CANCER _____

MOST RECENT PAP TEST (FEMALE PATIENTS ONLY): _____

RESULTS OF RECENT PAP TEST: CIRCLE ONE: NEGATIVE or POSITIVE for CERVICAL CANCER _____

ALLERGIES: PLEASE CHECK APPLICABLE BOX AND PROVIDE AN EXPLANATION OF REACTION (i.e. – RASH, SWELLING, SHORTNESS OF BREATH, VOMITING, ETC.)		
DRUG	<input type="checkbox"/>	
FOOD	<input type="checkbox"/>	
ENVIRONMENTAL	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>	

IN CONSIDERATION OF YOUR FELLOW PATIENTS AND OUR STAFF, PLEASE ANSWER THE FOLLOWING QUESTION:

ARE YOU AWARE OF THE PRESENCE OF BED BUGS IN YOUR HOME? YES: NO:

IF YES, WE MAY HAVE THE RESOURCES TO HELP YOU ERADICATE THEM. PLEASE DO NOT HESITATE TO ASK. WE ARE HERE TO HELP.

Malnutrition Screening Tool

This is a Malnutrition Screening Tool which helps us to know more about your weight and the food you eat. Malnutrition can cause you to lose muscle and take longer to recover.

Your answers to the questions in the tool will assist our dietetic partners on how we can better help reduce your risk of malnutrition. Please choose the answers that apply to you.

Question 1. Within the last 6 months, have you lost weight without trying?	No	0	<input type="checkbox"/>
	Not sure	2	<input type="checkbox"/>
	Yes: <i>If yes, how much weight have you lost?</i>		
	2-10 lbs	1	<input type="checkbox"/>
	11-20 lbs	2	<input type="checkbox"/>
	21-30 lbs	3	<input type="checkbox"/>
	More than 30 lbs	4	<input type="checkbox"/>
	I have lost weight but not sure how much	2	<input type="checkbox"/>
Question 2. Have you been eating less food than usual because you have not been hungry?	No	0	<input type="checkbox"/>
	Yes	1	<input type="checkbox"/>
Add your score from question 1 and question 2.	Total MST score =		

MST score 0-1

Your score shows you are at low risk of malnutrition

If you do start to lose weight or eat less than usual, you might become at risk of malnutrition. If this happens make sure to tell your doctor or nurse.

MST score 2

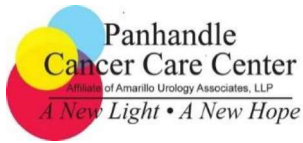
Your score shows you might be at risk of malnutrition.

You need to talk to your doctor or nurse about your weight and eating. Our team will work with our partners to schedule you an appointment with a dietitian.

MST score 3-5

Your score shows you are at risk of malnutrition.

You need to see a dietitian. Our team will assist you with placing a referral for an appointment with our dietetic partners.



Patient Health Questionnaire-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3
FOR OFFICE CODING <u>0</u> + _____ + _____ + _____				
=Total Score: _____				

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 ⑤	Somewhat difficult ⑤	Very difficult ⑤	Extremely difficult ⑤
------------------------------	----------------------------	------------------------	-----------------------------

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

About the I-PSS

The International Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms and one question concerning quality of life. Each question concerning urinary symptoms allows the patient to choose one out of six answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

The questions refer to the following urinary symptoms:

Questions	Symptom
1	Incomplete emptying
2	Frequency
3	Intermittency
4	Urgency
5	Weak Stream
6	Straining
7	Nocturia

Question eight refers to the patient's perceived quality of life.

The first seven questions of the I-PSS are identical to the questions appearing on the American Urological Association (AUA) Symptom Index which currently categorizes symptoms as follows:

- Mild (symptom score less than or equal to 7)
- Moderate (symptom score range 8-19)
- Severe (symptom score range 20-35)

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), recommends the use of only a single question to assess the quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of benign prostatic hyperplasia (BPH) Symptoms or quality of life, it may serve as a valuable starting point for a doctor-patient conversation.

The SCI has agreed to use the symptom index for BPH, which has been developed by the AUA Measurement Committee, as the official worldwide symptoms assessment tool for patients suffering from prostatism.

The SCI recommends that physicians consider the following components for a basic diagnostic workup: history; physical exam; appropriate labs, such as U/A, creatine, etc.; and DRE or other evaluation to rule out prostate cancer.

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: _____

TODAY'S DATE: _____

PATIENT INSTRUCTIONS

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 you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

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: _____

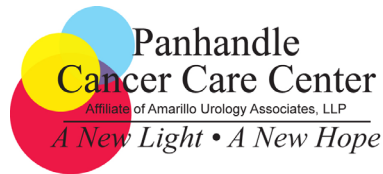
The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED

8-11 Moderate ED

12-16 Mild to Moderate ED

17-21 Mild ED



Panhandle Cancer Care Center
1655 Point West Pkwy
Amarillo, TX 79124
Phone: (806) 354-0950
Fax: (806) 356-1935

PATIENT FINANCIAL POLICY SHEET

To reduce confusion and misunderstanding between our patients, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our billing and insurance office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa, MasterCard, Discover and American Express.

Insurance:

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Billing:

- All billing statements from Panhandle Cancer Care Center will fall under the provider name Amarillo Urology Associates since we are associated with their practice. If you are mailing in a payment please make a note on the check that it is for Dr. Ahmed.

Minors:

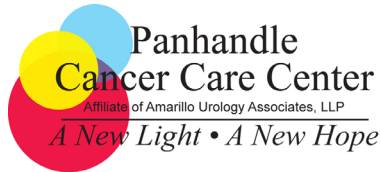
- For all services rendered to minor patients, the parent or guardian will be responsible for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient

Signature of Patient or Responsible Party if a Minor

Date



Panhandle Cancer Care Center
1655 Point West Pkwy
Amarillo, TX 79124
Phone: (806) 354-0950
Fax: (806) 356-1935

NOTICE OF PRIVACY PRACTICES

I have been informed that Amarillo Urology Associates, L.L.P. has a Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that upon request, I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

_____/_____/_____

Date

Name of Patient or Personal Representative
(Printed Name)

Personal Representative relationship to Patient
(Printed Name)

I authorize that my medical information can be released as follows:

Information to be released to:

Information to be released to:

Name/Relationship to Patient/Phone #
(Printed Name)

Name/Relationship to Patient/Phone #
(Printed Name)

Signature of Patient

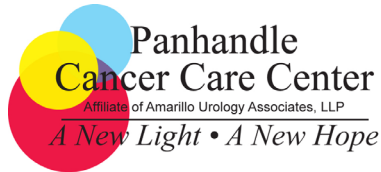
Signature of Patient

_____/_____/_____

_____/_____/_____

Date

Date



Panhandle Cancer Care Center
1655 Point West Pkwy
Amarillo, TX 79124
Phone: (806) 354-0950
Fax: (806) 356-1935

Irfan Ahmed, M.D.

PRESCRIPTION MEDICATION NOTICE

Due to the rapidly changing policies and drug formularies of insurance companies, we are unable to assist with the pre-authorization requests being made by them. Your prescription drug coverage is a contract between you and your insurance provider. You, the patient must contact your insurance company to obtain pre-authorization if needed.

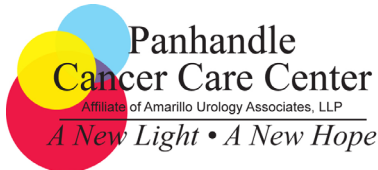
If we are notified a pre-authorization is required, we will direct your pharmacy to contact you. They can provide you with the phone number needed to obtain the pre-authorization. We will provide you with a copy of your chart note indicating the medication ordered and the reason for the order.

*******THIS OFFICE DOES NOT REFILL PRESCRIPTIONS PRESCRIBED BY OTHER PHYSICIANS*******

Signature of Patient or Personal Representative

____/____/_____
Date

Name of Patient or Personal Representative
(Printed Name)



Panhandle Cancer Care Center
1655 Point West Pkwy
Amarillo, TX 79124
Phone: (806) 354-0950
Fax: (806) 356-1935

Patient Name: _____

PATIENT COMMUNICATION INFORMATION

Due to the fact that **we have electronic medical records**, we have the ability to provide you with your health information in a variety of ways.

Please choose a delivery method for each of the following categories:

You do not have to choose any of the delivery methods from the categories below and you may choose **NONE** as an option.

Please only choose **one** delivery method for each category

	Print Copy	E-Mail	Portable Media (USB or CD)	Patient Portal (online access to your information)	Text Message	None
Patient Health Information						
Appointment Reminders						
Visit Summary						

If you choose Patient Portal you will be given instructions after your appointment on how to access the system.

Please provide the following information to keep our records current:

E-Mail Address: _____

Cell Phone #: _____

Cell Phone Carrier	AT&T	Sprint	Verizon	Cellular One	T-Mobile

Other cell phone carrier not listed above: _____

If you have any questions, please don't hesitate to ask for assistance.

Thank You,
 Panhandle Cancer Care Center Staff