Robert J. Cornell, MD, PA

General Adult & Prosthetic Urology

Diplomate American Board of Urology

Patient Registration- (Please print clearly)

Patient Name: _____ Home Phone: _____
Last First Middle

Patient Address: _____
Street City State Zip

Alternate Contact Information: Cell: _____ Email: _____

Patient Date of Birth: _____ Age: _____ Sex: Male ☐ Female ☐

Social Security #: _____ Occupation: _____

Employer: _____ Business Phone: _____

Name of Spouse: _____ Occupation: _____

Referring Doctor: _____ Phone: _____

Primary Doctor: _____Phone: _____

Preferred Pharmacy: _____

Phone: _____ Fax: _____

Insurance Information

PRIMARY INSURANCE: _____

Subscriber Name: _____Self ☐ Spouse ☐ Parent ☐

Subscriber Birthdate: _____ Member #: _____ Group #: _____

In case of emergency, local friend or relative to be notified:

Name: _____ Phone: _____

Relationship to Patient: _____

I understand that my insurance {s) will be filed, as a courtesy, but I remain solely responsible to Robert J. Cornell, M.D. for all charges incurred. I hereby authorize Robert J. Cornell, M.D. and/or its representative to release any and all information necessary to process my insurance claim(s). I hereby authorize my insurance company {s) to pay benefits directly to Robert J. Cornell, M.D. I hereby authorize Robert J. Cornell, M.D. to release my medical records to other physicians who may also provide medical care to me.

Signature: _____ Date: _____

1315 St. Joseph Parkway, Ste 1700 | Houston, TX 77002 | p (713) 652-5011 | f (713) 654-4056
www.urosurgeryhouston.com

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Patient's Medical History

Patient Name: _____ Date: _____

Sex: Male ☐ Female ☐ Age: _____ Marital Status: _____

How did you hear about Dr. Cornell/Dr. Clavell? _____

Work Status: Presently Working: _____ Retired: ☐ Disabled ☐

Reason for visit today: _____

Height: _____ Weight: _____

Do you smoke: No ☐ Yes ☐ If yes, How long? _____ Number of packs per day? _____

Do you drink Alcohol: No ☐ Si ☐ If yes, How much? _____

Ongoing medical illnesses (include diagnosis): _____

_____

Prior Surgery including Month/Year: _____

_____

_____

Other Hospitalizations including Month/Year: _____

_____

List current Medicines you are taking (including dosage): _____

_____

_____

List Allergies to Medicines: _____

_____

Family History/Diseases: _____

_____

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Patient Name: _____ Date: _____

*****Males Only*****

Erectile Dysfunction No ☐ Yes ☐ When was your last Pneumococcal Vaccine? _____

Urinary Leakage No ☐ Yes ☐ When was your last colonoscopy done? _____

Number of times awakened to urinate at night: _____

*****Females Only*****

Urinary Leakage No ☐ Yes ☐ Urinary Frequency: No ☐ Yes ☐

Are you pregnant? No ☐ Yes ☐ # of Pregnancies _____# of Children: _____

Please check if you have now or have had in the past any of the following:

☐ Anemia	☐ Diverculitis	☐ Leg/Foot Disorder	☐ Rheumatic Fever
☐ Anesthesia Issues	☐ Emphysema	☐ Leukemia	☐ Shingles
☐ Arthritis	☐ Eye Disorder	☐ Paralysis	☐ Thyroid Condition
☐ Asthma	☐ Gout	☐ Mental Illness	☐ Skin Disorders
☐ Back Problems	☐ Heart Attack	☐ Nerve Disorder	☐ Ulcers
☐ Bladder Infections	☐ HIV/AIDS	☐ Osteomyelitis	☐ Stroke
☐ Blood in Urine	☐ Hypertension	☐ Prostate Disorder	☐ Venereal Disease
☐ Bleeding Disorders	☐ Heart Murmur	☐ Phlebitis	☐ Tuberculosis
☐ Bronchitis	☐ Hepatitis	☐ Polio	☐ Vein Clot
☐ Cancer	☐ Liver Disorders	☐ Poor Circulation	
☐ Diabetes	☐ Kidney Disorders	☐ Sickle Cell	
☐ Gastritis	☐ Kidney Stones	☐ Rash	

Other Conditions: _____

This information is correct to the best of my knowledge.

_____ _____

Patient's Signature Date

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Acknowledgement- Privacy Policies Reviewed

I have reviewed this office's Notice of Privacy practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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Assignment of Benefits

I hereby authorize payment of benefits directly to the physician for the surgical and/or medical services herein specified. I am aware of my responsibility to pay any non-covered service, as well as any co-pay, coinsurance; and/or deductible due at the time of treatment.

_____ _____

Patient's Signature Date

Release of Information

I hereby authorize the physician to release any information acquired in the course of my examination, treatment, or surgery for billing and treatment purposes only.

_____ _____

Patient's Signature Date

I authorize the physician to release my personal health information to the following people:

_____

_____ _____

Patient's Signature Date

Cancellation Policy

Please understand that we request a 24-hour cancellation notice. Failure to notify us within 24 hours of a scheduled appointment will result in a $50.00 fee due on or before your next visit. Please speak to an office representative for clarification of any concerns.

_____ _____

Patient's Signature Date

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LAB NOTIFICATION

Laboratory testing of certain important clinical variables will be offered on site if it is believed your insurance is contracted to reimburse the practice for these services. Should your insurance deny this coverage or request a refund of payment for this service, you will be responsible for an amount determined by the practice as fair and reasonable compensation.

You are free to inquire about this price at any time before your services are rendered and to choose an outside lab for the same testing, also potentially at your expense.

_____ _____

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International Prostate Symptom Score (I-PSS)

Patient 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	Your Score
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you 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	
	None	1 time	2 times	3 times	4 times	5 times or more	
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	
Total I-PSS Score							
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
Quality of Life Due to Urinary Symptoms If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯

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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

Patients 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?	DO 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?	DO 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?	DO 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**

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