Patient Information Form
Dr L. Carlo Yuen

TITLE: _____ FIRST NAME: _____ LAST NAME: _____

MIDDLE NAME: _____

STREET ADDRESS (**No PO Boxes allowed**): _____

_____ POST CODE :_____

DATE OF BIRTH _____

PHONE: HOME _____ MOBILE: _____

WORK: _____

EMAIL: _____

FAMILY MEMBER: **NAME** AND **PHONE NUMBER**: _____ _____

MEDICARE NUMBER: _____NUMBER (before name): _____ VALID TO: _____

PRIVATE HEALTH FUND: _____ MEMBERSHIP NUMBER: _____

DEFENCE REPAT GOLD CARD NUMBER: _____

REFERRING DOCTOR : _____

LOCAL DOCTOR (GP) AND ADDRESS _____

ALLERGIES: _____

MEDICAL CONDITIONS AND SURGERIES (e.g. Diabetes, Heart disease, Infectious Diseases): _____

_____

MEDICATIONS (Including vitamins) _____

_____

DO YOU TAKE MEDICATIONS TO THIN YOUR BLOOD: YES NO If Yes, what is the name _____

PRIVACY ACT

As a patient of Dr Yuen, a medical record containing personal information will be maintained throughout your treatment. This record will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor's details. During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to 7 years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available on request. By signing this document, you are indicating that you have understood and agree with the condition of our privacy policy.

SIGNED:……DATE:……

MALE PATIENTS – PLEASE COMPLETE NEXT PAGE

International Prostate Symptom Scoresheet (IPSS)

PATIENT NAME _____

DOB_____ DATE _____

Age Group 40-49 ☐ 50-59 ☐ 60-69 ☐ 70+ ☐

OVER THE PAST MONTH – Please circle your choice of answer below

	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 **How often have you had the sensation of not emptying your bladder completely after you finished urinating**	**0**	**1**	**2**	**3**	**4**	**5**	
2. FREQUENCY **How often have you had to urinate in less than two hours after you finished urinating?**	**0**	**1**	**2**	**3**	**4**	**5**	
3. INTERMITTENCY **How often have you found you stopped and started 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 push or strain to begin urinating?**	**0**	**1**	**2**	**3**	**4**	**5**	

PLEASE CIRCLE YOUR FREQUENCY OF URINATION BELOW

7. NOCTURIA **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 PROSTATE SYMPTOM SCORE _____

(0- 7) Mild (8 – 19) Moderate (20 – 35) Severe