NEW PATIENT REGISTRATION FORM

DR LOVE
UROLOGICAL SURGEON

Dr Christopher Love
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Provider No. 0494287F

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CONSULTING AT:
Bayside Urology
66 Balcombe Road
Mentone VIC 3194

Men's Health Melbourne
Level M 233 Collins St
Melbourne VIC 3000

SPECIALISTIN:
Penile Implant Surgery
Erectile Dysfunction
Peyronie's Disease
BPH Management
Greenlight Laser
Penile Rehabilitation
Incontinence after Cancer
"No Scalpel" Vasectomy
Men's Health Advice
Stone Disease
General Urology

Date:_____

Name: _____

Address: _____

_____

Age: _____ Date of Birth: _____

We would like to send a letter to update your referring doctor. Y N

Referring Doctor: _____

Telephone Number: _____

Address: _____

_____

Chief Complaint:

What is the main reason for your visit today (please describe in detail)?

_____

_____

Past Medical and Social History:

1. Do you have any medical illnesses or conditions?
Circle any of the following that apply:
   - High blood pressure
   - High cholesterol levels
   - Heart disease
   - Diabetes

Details:

_____

_____

_____

2. List all serious illnesses in your immediate family.

_____

_____

3. List any personal treatments and operations and when they occurred.

   - Surgery _____Date _____
   - Surgery _____Date _____
   - Surgery _____Date _____
   - Radiation Therapy _____Date _____
   - Chemotherapy _____Date _____

4. Drug Allergies: Y N

Please list:_____

_____

5. Medications: Y N

Please list all drugs, medications, eye drops, etc. currently being taken

_____
_____
_____
_____

Do you take any medications that fall into the category of nitrates? Y N
Do you carry nitro-glycerine with you in case of heart pain? Y N
Do you use a skin patch for the delivery of medications? Y N

6. Alcohol Intake: Do you drink alcohol (beer, wine, liquor, etc.)? Y N

If yes: Type _____ Amount _____

7. Tobacco Use:
Do you or did you ever smoke? Y N
If yes: How many pack(s) per day? _____
For how many years? _____ If you stopped, how long ago? _____

8. Psychological History:
Have you ever consulted a psychiatrist, psychologist, or other psychotherapist? Y N
If yes, please describe the reason: _____
_____
_____
Were you diagnosed with any of the following:
Depression? Y N
Obsessive-compulsive disorder? Y N
Bipolar disorder? Y N
Psychosis/Neurosis? Y N

Review of Other Symptoms

Do you now or have you had any problems related to the following symptoms? Circle Yes or No.
Please explain any "Yes" answers in the space provided.

Constitutional Symptoms

Fever	Yes No
Chills	Yes No
Headaches	Yes No
Weight loss	Yes No
Other _____	Yes No

Eyes

Blurred vision	Yes No
Double vision	Yes No
Pain	Yes No
Other _____	Yes No

Neurological

Tremors	Yes No
Dizzy spells	Yes No
Numbness	Yes No
Other _____	Yes No

Respiratory

Wheezing	Yes No
Frequent coughs	Yes No
Shortness of breath	Yes No
Other _____	Yes No

Haematological /Lymphatic

Swollen glands	Yes No
Blood clot problems	Yes No
Other _____	Yes No

Gastrointestinal

Abdominal pain	Yes No
Nausea/ vomiting	Yes No
Indigestion	Yes No
Other _____	Yes No

Skin

Rash	Yes No
Boils	Yes No
Persistent itch	Yes No
Other _____	Yes No

Musculoskeletal

Joint pain	Yes No
Neck pain	Yes No
Back pain	Yes No
Other _____	Yes No

Cardiovascular

Chest pain	Yes No
Varicose veins	Yes No
High blood pressure	Yes No
Cholesterol issues	Yes No
Other _____	Yes No

Endocrine

Excessive thirst	Yes No
Too hot/cold	Yes No
Tired/sluggish	Yes No
Other _____	Yes No

Respiratory

Wheezing	Yes No
Frequent coughs	Yes No
Shortness of breath	Yes No
Other _____	Yes No

Allergic / Immunologic

Hay fever	Yes No
Drug allergies	Yes No

List:_____
_____
_____
_____

Other _____ Yes No

Ear/ Nose/ Throat/ Mouth

Ear infection	Yes No
Sore throat	Yes No
Sinus problems	Yes No
Other _____	Yes No

Genitourinary

Urine flow problems	Yes No
Painful urination	Yes No
Urinary frequency	Yes No
Other _____	Yes No

YOUR PREFERENCE FOR US COMMUNICATING WITH YOU

PATIENT NAME: _____ Date of Birth_____

We often need to contact you with information about your condition or results of tests.
You may request to receive communication about your health information in whatever way you prefer, or at an alternative address.
For example, you may not want your appointment or billing statement to be mailed to your home where it may be seen by others.
Please **select all that applies**. Sign and date below.

I. HEALTH INFORMATION

Laboratory, X-ray, test results, billing statements, and/or any correspondence pertaining to health information.
I authorize Dr. Christopher Love, or his staff members to leave my messages at the following:

☐ DO NOT LEAVE A MESSAGE OTHER THAN TO ASK ME TO RETURN THE CALL
☐ Y ☐ N Leave results on answering machine or voice mail
☐ Y ☐ N Home phone _____
☐ Y ☐ N Work phone_____
☐ Y ☐ N Mobile phone_____
☐ Y ☐ N Please mail my results to:
_____

II. OTHER PERSON(S) AUTHORISED TO RECEIVE MY INFORMATION

☐ Yes ☐ No

_____

Name Telephone Number Relationship to you

III. BILLING STATEMENTS AND CORRESPONDENCE:

Any correspondence related to your bills will be automatically mailed to your home address, unless indicated otherwise.
Do you agree to this? ☐ Yes ☐ No If no please provide an alternate address:

_____

Address City State Post Code

IV. AUTOMATED REMINDER CALLS AND MESSAGES:

We are currently utilizing a reminder service, which sends a SMS message to your mobile phone. It remind you of the date and time of your appointment. You have the right to request not to be contacted or change your request at any time to terminate this service.

☐ Yes I wish to be reminded of my upcoming appointments using this reminder service.
☐ No I do not wish to be reminded of my upcoming appointments using this reminder service.

V. MAY WE CONTACT YOU VIA E-MAIL WITH FURTHER MEDICAL INFORMATION? ☐ Yes ☐ No

_____

Email address

Thank you for assisting us to serve you more effectively.

PATIENT SIGNATURE (or Legal Representative)

_____ Date:_____

Relationship, if Legal Representative: _____

For Staff Use Only: ***Preferences Noted:*** ***Date:*** ***Staff Initials:***

PATIENT PRIVACY CONSENT CLAUSE

We require your consent to enable us to handle personal information about you.
Please read the **Privacy Policy available on the website** carefully and sign where indicated below.
If you have any concerns or queries about this, please feel free to ask us for a further explanation.

"I have read this practice's Privacy Policy and understand the reasons why my information must be collected, and agree to these privacy policies.
I understand that I am not obligated to provide any information requested of me but that my failure to do so might compromise the quality of the health care and treatment given to me.
I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
I understand that if my information is to be used for any other purpose, other than set out in the Privacy Policy, my further consent will be obtained.
I consent to the handling of my information by this practice for the purposes set out in the Privacy Policy handed to me today, subject to any limitations on access or disclosure that I notify this practice of.
I consent that this practice can collect personal information about me from other members of the treating team e.g., hospitals, pathologists, radiologists, general practitioners, other specialists, para-medical therapists etc., to enhance the quality of the health care and treatment given to me by Dr Christopher Love, his associates and staff.
I consent that Dr. Christopher Love can disclose health information about me to an immediate family member or relevant others (spouse, de facto spouse, parent, child, guardian, person exercising enduring Power of Attorney, person nominated by an individual to be contacted in case of emergency) as indicated on your communication.
I agree to the collection, use and disclosure of medical information collected about me as outlined in the Privacy Policy of this practice and the issues raised in this consent form."

NAME: .....

ADDRESS:.....

POSTCODE: ..... DOB: .....

PH NO: ..... MOB: .....

Signed: - ..... Date: - .....

Witnessed: -.....

Thank you in advance for filling out this quick survey.

How did you find out about Dr. Love?

- ☐ *Referred by my own doctor*
- ☐ *Word of mouth – "a friend told me"*
- ☐ *Newspaper*
  - o *Age*
  - o *Herald – Sun*
  - o *Leader*
- ☐ *Magazine*
- ☐ *Radio*
- ☐ *Internet / Website*
  - o *Google search*
  - o *www.drlove.com.au*
  - o *www.loveurology.com.au*
  - o *www.fixED.net.au*
  - o *www.baysideurology.com.au*
  - o *Other site:* _____
- ☐ *Other source, please specify:* _____