Center of Excellence
FOR PENILE IMPLANTS

NEW PATIENT REGISTRATION FORM

Dr Christopher Love
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M.B. B.S. F.R.A.C.S.
Provider No. 049428.A.L

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CONSULTING AT:

Urology South,
Level 2,
Holmesglen Private Hospital,
490 South Rd.,
Moorabbin VIC 3189

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
-Rezum
-UroLift
Penile Rehabilitation
Incontinence after Cancer
"No Scalpel" Vasectomy
Men's Health Advice
Stone Disease
General Urology

Date:..................................

Name:..

Address:...

....

Age: .... Date of Birth:..

Telephone number: Landline..Mobile..

Email address: ....

Medicare number: ....Ref. No...........DVA Gold Card? ....

Private Health Insurance: Fund ....Membership number ....

Referring Doctor details:

Name: ....

Address: ....

If this is not your GP - who is your GP?
Name:..
Address:..

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

....

....

....

Past medical problems:

....

....

....

1. Do you have any of these medical illnesses or conditions?

High blood pressure	High cholesterol levels	Heart disease
Diabetes	Angina	Cardiac stents

Details:...

....

2. List all serious illnesses in your immediate family.

....

3. List any past medical treatments or procedures:

....
....
....

4. Are you taking any 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

5. Are you allergic to any medications? If so, please list: . Y N

....
....

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

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:

Were you diagnosed with any of the following:

Depression?	Y N
Obsessive-compulsive disorder?	Y N
Bipolar disorder?	Y N
Psychosis/Neurosis?	Y N

<u>**Review of Other Symptoms**</u>

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 (General) 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 in eyes	Yes / No
Other	Yes / No

Neurological

Tremors	Yes / No
Dizzy spells	Yes / No
Numbness	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

Haematological / Lymphatic

Swollen glands	Yes / No
Blood clot problems	Yes / No
Excessive bleeding	Yes / No
Other	Yes / No

Gastrointestinal

Abdominal pain	Yes / No
Nausea/ vomiting	Yes / No
Indigestion	Yes / No
Blood in bowel motions?	Yes / No
Other	Yes / No

Ear/ Nose/ Throat/ Mouth

Ear infection	Yes / No
Sore throat	Yes / No
Sinus problems	Yes / No
Hay fever?	Yes / No
Other	Yes / No

Genitourinary

Urine flow problems Painful urination	Yes / No
Urinary frequency	Yes / No
Blood in urine?	Yes / No
Wake up at night to pass urine?	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:***

UROLOGY SOUTH PATIENT CONSENT CLAUSE

We require your consent to enable us to handle personal information about you. Please read the Privacy Policy 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 Urology South (Mr Chris Love).

I consent that Urology South 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) unless disclosure is contrary to a wish expressed by yourself on a prior occasion.

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."

FEES: In accordance with standard business practice, payment is requested at the time of consultation. Please note payment is required on the day of appointment. Any outstanding invoice that requires Debt Collection will attract an additional 20% to cover costs incurred.

There maybe additional charges associated with your consultation, as recommended by your specialist, for tests such as radiology and pathology.

NAME: ....

ADDRESS: ....

....

Date Of Birth: ....

Signed: - ....

Witnessed: -.......................................

Date: - ....

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 Ad*
    - o *Age*
    - o *Herald – Sun*
    - o *Leader Newspaper*
- ☐ *Magazine Ad*
- ☐ *Radio Ad*
- ☐ *Internet / Website*
- ☐ *Facebook Ad*
    - o *Google search*
    - o *www.drlove.com.au*
    - o *www.loveurology.com.au*
    - o *Other site:*

  ____

- ☐ *Other source, please specify:*

  ____