

Allergy
Audiology
Family Medicine
Medical Oncology
Otolaryngology
Pain Management
Urology

Thank for you for selecting Jefferson at the Navy Yard for your care.

We ask that you arrive 15 minutes prior to your scheduled visit. Should you need to cancel or re-schedule your visit for any reason, we require that you contact 1-800 JEFF NOW (1-800-533-3669) within 48 hours prior to your scheduled visit.

Also, if you arrive for your appointment 15 minutes beyond the scheduled time, you may be asked to reschedule your appointment for another day and time. To best prepare for your visit kindly make sure to bring the following items with you:

- Insurance card
- Referral form (if applicable)
- Request for consultation by your referring physician (if applicable)
- Photo ID - this is a requirement of federal regulations
- Payment for services - cash, check or credit card. Please note that co-payments are contractually required and must be paid at the time of the visit.

In addition, it may be necessary for you to bring medical information with you. The following items need to be brought with you to the office on the day of your visit if applicable:

- Medical records including information associated with a recent hospitalization, for example: Discharge Summary or Operative Note
- Diagnostic Studies (MRI, CAT Scan, Ultrasounds) - including the films and written reports.
- Pathology or Lab Studies - results of recent lab work or pathology slides and reports.
- A list of all medication - prescribed, over the counter and herbal supplements.

Enclosed are several documents that you will need to complete in advance of your visit. By doing so, you will ensure that your scheduled appointment time with your provider is not further delayed.

For additional information you can visit our website:
www.jeffersonhospital.org/navyyard

Today's Date:

Please complete this form in order to ensure proper billing of your services. Please Print.

Patient's Last Name		Patient's First Name		MI
DOB / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - -	Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	
Race <input type="checkbox"/> African American or Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Unknown <input type="checkbox"/> Declined				
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined				
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____				
Address Line 1		Address Line 2		
City			State	Zip
Home Phone		Daytime Phone		Cell Phone
Home E-mail				
Emp Status <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Other _____				
Employer				Work Phone
Employer's Address Line 1		Employer's Address Line 2		
City			State	Zip

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor's Last Name		Guarantor's First Name		MI
DOB / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - -	Patient's Relationship to the Guarantor	Home Phone
Guarantor's Address Line 1		Guarantor's Address Line 2		
City			State	Zip
Guarantor's Employer				
Guarantor Employer's Address Line 1		Guarantor Employer's Address Line 2		
City			State	Zip

Emergency Contact Information

Emergency Contact's Last Name		Emergency Contact's First Name		MI
Patient's Relationship to the Emergency Contact		Daytime Phone		Cell Phone

Please select the source in which you heard of our practice

<input type="checkbox"/> Billboard	<input type="checkbox"/> Brochure	<input type="checkbox"/> Health Fair	<input type="checkbox"/> Health Plan	<input type="checkbox"/> Internet	<input type="checkbox"/> JEFF NOW®	<input type="checkbox"/> Mass Mailing	<input type="checkbox"/> Newspaper/Mag.	<input type="checkbox"/> Ongoing Care
<input type="checkbox"/> Patient	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Phys. Off./ER	<input type="checkbox"/> Relative	<input type="checkbox"/> Radio	<input type="checkbox"/> TV	<input type="checkbox"/> Word of Mouth	<input type="checkbox"/> Other _____	

Insurance Information A separate form is required for workers' compensation, automobile liability, or legal services.

Primary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	
Secondary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	

Patient Name: _____ Date of Birth: _____
(Please Print)

MRN: _____

Associated Providers

Please list any physicians below who should receive information regarding your care/visit.

Primary Care Provider

Name: _____ Specialty: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Referring Provider

Name: _____ Specialty: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Pharmacy Information

Please complete your pharmacy information below.

Retail Pharmacy

Name: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Mail Order Pharmacy

Name: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Laboratory/Radiology InformationAre your laboratory and radiology studies capitated to a specific performing location? Y N

Laboratory: _____ Radiology: _____



Patient Name: _____ Date of Birth: _____
(Please Print)

MRN: _____

Part A

You have informed Jefferson University Physicians (JUP) that in certain circumstances, you would like us to share your medical information with specified individuals (e.g., your spouse, mother, etc.).

JUP agrees to communicate with persons whom you designate regarding your protected health information. This agreement will remain in effect unless you provide us with written notice to terminate this consent.

Part B

I hereby grant Jefferson University Physician's department/division of

permission to communicate my protected health information to the following individuals:

Name:	Relationship:
Address:	Telephone #:
_____	_____

Name:	Relationship:
Address:	Telephone #:
_____	_____

Name:	Relationship:
Address:	Telephone #:
_____	_____

Name:	Relationship:
Address:	Telephone #:
_____	_____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____



TW MRN # _____

Medical History Questionnaire

Provider you are seeing today: _____ Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Please state your problem in your own words as to why you are here today:

Did a physician request that you see one of our providers today? Yes No If yes, name of physician: _____

Past Medical History (check all that apply):		<input type="checkbox"/> No Past Medical History
<input type="checkbox"/> Acute Myocardial Infarction (Heart Attack)	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia (Low Blood Count)	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Pulmonary Disease (Lung Disease)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatic (Liver) Disorder	<input type="checkbox"/> Recent Methicillin-resistant Staph aureus (MRSA)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Autoimmune Disorder (Lupus/Scleroderma/RA)	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Blood Transfusion Complications	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Seizure Disorder
	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Cancer - list type(s):	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Stroke Syndrome
	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thromboembolic Disease (Blood Clot Disorder)
	<input type="checkbox"/> Lower Back Pain	
<input type="checkbox"/> Chest Pain (Angina)	<input type="checkbox"/> Mitral Valve Disorder	<input type="checkbox"/> Thrombophlebitis
<input type="checkbox"/> Chronic Liver Disease	<input type="checkbox"/> Murmurs	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease)	<input type="checkbox"/> Obesity	<input type="checkbox"/> Transient Ischemic Attack (Mini Stroke)
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Peripheral Vascular Disease (Poor Circulation)	
<input type="checkbox"/> Gastric/Duodenal Ulcer		

Surgery:	<input type="checkbox"/> No Surgical History	Date

Family History:		<input type="checkbox"/> No Family Medical History	
(check all that apply)	Family Member*	(check all that apply)	Family Member*
<input type="checkbox"/> Anemia (Low Blood Count)		<input type="checkbox"/> Hypercholesterolemia	
<input type="checkbox"/> Cancer - list type(s):		<input type="checkbox"/> Hypertension	
		<input type="checkbox"/> Osteoporosis	
		<input type="checkbox"/> Pulmonary Disease	
<input type="checkbox"/> COPD		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Stroke Syndrome	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Thromboembolic Disease	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Unattainable-Patient Adopted	
<input type="checkbox"/> Hepatic (Liver) Disorder		<input type="checkbox"/> Other:	
Family Health Status of Father – Deceased	Age: _____ Cause: _____		
Family Health Status of Mother – Deceased	Age: _____ Cause: _____		

***Please indicate the family member affected: mother, father, brother, sister, maternal or paternal grandmother/grandfather, etc.**

Medical History Questionnaire

Patient Name _____

DOB _____

TW MRN# _____

PAGE 2 of 2

Social History:

Marital Status: Married Single Widowed Separated Divorced Life Partner

(check all that apply):

Alcohol Use Weekly: _____

Drug Use (Recreational) Explain: _____

Using Intravenous Drugs Explain: _____

Previous History of Smoking

Date Quit: _____ Packs Per Day _____ Years of Smoking: _____

Attempts to Quit: _____ Methods Used to Quit: _____

No History of Smoking

Wishing to Stop Smoking

Smoking/Nicotine Substances Cigarettes Cigars Chewing Tobacco Pipe

Packs/Times Per Day: _____ Years _____

Current Diet Explain: _____

Exercise Habits Times per week: _____

Being Sedentary (Do not exercise)

Sexually Active

Occupation List All: _____

Travel If recently out of the country, where? _____

Do you have an advanced directive? Yes No

Do you have the following symptoms now? No Known Symptoms

Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain on Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent Wt Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeling Tired	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limb Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyesight Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nasal Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limb Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Allergies:

No Known Allergies

Allergy	Reaction

Medications (Include vitamins, herbal supplements and over the counter medications):

No Current Medications

Medications	Dosage	Frequency	Reason for Taking

Have you participated in any clinical trials or used experimental drugs? Yes No Explain: _____

Are you pregnant? Yes No Last Menstrual Period Date: _____

Is there anything else about your medical history that we should know? _____

Patient Signature: _____ Date: _____

I certify that I have reviewed the above information with the patient.

Physician Signature: _____ Date: _____

NAME _____ DOB _____ DATE _____

Jefferson Urology Associates

International Index of Erectile Function

You are asked to complete the following health questionnaire. If you are uncomfortable with the questions asked on this form, you may choose not to complete this questionnaire.

Your doctor will review your answers to this questionnaire. If you have any questions or concerns regarding this questionnaire, please discuss them directly with your physician.

All questions refer to the timeframe of "Over the past 4 weeks"

1. How often were you able to get an erection during sexual activity?
0=No sexual activity
1=Almost never/never
2=A Few times (much less than half the time)
3=Sometimes (about half the time)
4=Most times (much more than half the time)
5=Almost always/always
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?
0=No sexual activity
1=Almost never/never
2=A Few times (much less than half the time)
3=Sometimes (about half the time)
4=Most times (much more than half the time)
5=Almost always/always
3. When you attempted sexual intercourse, how often were you able to penetrate (enter) your partner?
0=Did not attempt intercourse
1=Almost never/never
2=A Few times (much less than half the time)
3=Sometimes (about half the time)
4=Most times (much more than half the time)
5=Almost always/always
4. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?
0=Did not attempt intercourse
1=Almost never/never
2=A Few times (much less than half the time)
3=Sometimes (about half the time)
4=Most times (much more than half the time)
5=Almost always/always
5. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
0=Did not attempt intercourse
1=Extremely difficult
2=Very difficult
3=Difficult
4=Slightly difficult
5=Not difficult
6. How do you rate your confidence that you could get and keep an erection?
1=Very low/none at all
2=Low
3=Moderate
4=High
5=Very high

Erection: _____

7. How many times have you attempted sexual intercourse?

- 0=No attempts
- 1=Almost never/never
- 2=Three to four attempts
- 3=Five to six attempts
- 4=Seven to ten attempts
- 5=Eleven + attempts

Name: _____

DOB: _____

8. When you attempted sexual intercourse, how often was it satisfactory to you?

- 0=Did not attempt intercourse
- 1=Almost never/never
- 2=A Few times (much less than half the time)
- 3=Sometimes (about half the time)
- 4=Most times (much more than half the time)
- 5=Almost always/always

9. How much have you enjoyed sexual intercourse?

- 0=No intercourse
- 1=No enjoyment
- 2=Not very enjoyable
- 3=Fairly enjoyable
- 4=Highly enjoyable
- 5=Very highly enjoyable

Intercourse

Satisfaction _____

10. When you have sexual stimulation or intercourse, how often did you ejaculate?

- 0=No sexual stimulation/intercourse
- 1=Almost never/never
- 2=A few times (much less than half the time)
- 3=Sometimes (about half the time)
- 4=Most times (much more than half the time)
- 5=Almost always/always

11. When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?

- 0=No sexual stimulation/intercourse
- 1=Almost never/never
- 2=A few times (much less than half the time)
- 3=Sometimes (about half the time)
- 4=Most times (much more than half the time)
- 5=Almost always/always

Orgasmic

Function: _____

12. How often have you felt sexual desire?

- 0=No sexual stimulation/intercourse
- 1=Almost never/never
- 2=A few times (much less than half the time)
- 3=Sometimes (about half the time)
- 4=Most times (much more than half the time)
- 5=Almost always/always

13. How would you rate your level of sexual desire?

- 1=Very low/none at all
- 2=Low
- 3=Moderate
- 4=High
- 5=Very High

Sexual

Function _____

14. How satisfied have you been with your overall sex life?

- 1=Very dissatisfied
- 2=Moderately dissatisfied
- 3=About equally satisfied and dissatisfied
- 4=Moderately satisfied
- 5=Very satisfied

15. How satisfied have you been with your sexual relationship with your partner?

- 1=Very dissatisfied
- 2=Moderately dissatisfied
- 3=About equally satisfied and dissatisfied
- 4=Moderately satisfied
- 5=Very satisfied

Overall

Satisfaction: _____

Jefferson at the Navy Yard

AMERICAN UROLOGICAL ASSOCIATION SYMPTOM SCORE

D.O.B.: _____

NAME: _____

MRN: _____

DATE: _____

DURING THE LAST MONTH OR SO...	NOT AT ALL	LESS THAN 1 TIME IN 5	LESS THAN 1/2 THE TIME	ABOUT 1/2 THE TIME	MORE THAN 1/2 THE TIME	ALMOST ALWAYS
How often have you had the sensation of not emptying your bladder completely after you finish?	0	1	2	3	4	5
How often have you had to urinate again less than 2 hours after you have finished?	0	1	2	3	4	5
How often have you stopped and started urinating again several times when you urinated?	0	1	2	3	4	5
How often have you had a weak urinary stream?	0	1	2	3	4	5
How often have you found it difficult to postpone urination?	0	1	2	3	4	5
How often have you had to push or strain urination?	0	1	2	3	4	5
	NONE	1 TIME	2 TIMES	3 TIMES	4 TIMES	5 TIMES
How many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5
QUALITY OF LIFE	DELIGHTED	PLEASED	MOSTLY SATISFIED	MIXED	MOSTLY DISSATISFIED	TERRIBLE
How would you feel if you had to live with your condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5



From Center City

By Car

Take Broad Street south to the Navy Yard. Enter the Navy Yard and turn left at first light onto Crescent Drive.

By SEPTA

Take the Broad Street Subway (Orange Line) south to Pattison Avenue.

Take Bus #71 on the Southeast corner of Broad Street to the Navy Yard.

Exit at Crescent Drive.

From New Jersey via Walt Whitman Bridge

Cross the Walt Whitman Bridge.

After the toll booth, take Exit 349 (Broad Street/Sports Complex).

Turn left at the first light onto Broad Street.

Follow Broad Street approximately one mile to the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

From Delaware and Points South of Philadelphia

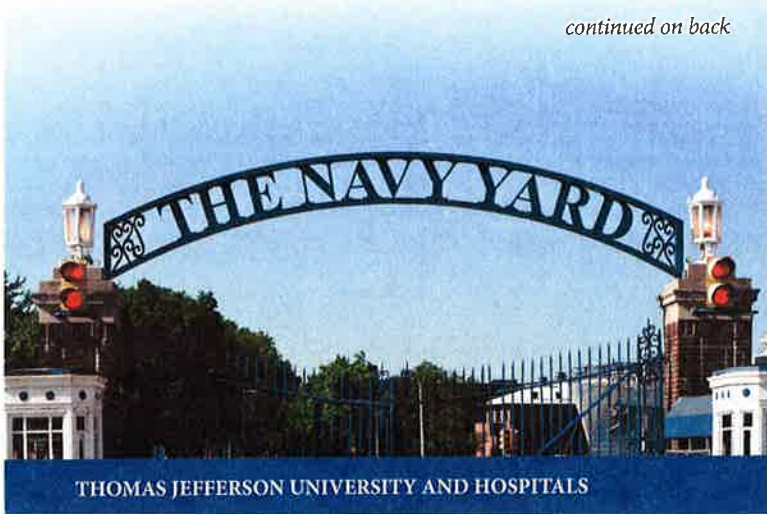
Take I-95 North to Exit 17 (Broad Street/Pattison Avenue).

Turn left at first light (Zinkoff Boulevard) and make immediate left onto Broad Street.

Get in right lane (avoid the entrance to I-95) and follow Broad Street into the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

continued on back



From Points North

Take I-95 South to Exit 17 (Broad Street/Pattison Avenue). Stay to the left.

Cross over Broad Street and then make a left onto Broad Street at the second light.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

From the Western Suburbs

Take 476 South to I-95 North.

Take I-95 North to Exit 17 (Broad Street/Pattison Avenue).

Turn left at the first light (Zinkoff Boulevard) and make an immediate left onto Broad Street.

Get in right lane (avoid the entrance to I-95) and follow Broad Street into the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

Parking

Free parking is available. The parking lot is located behind 3 Crescent Drive: Turn right at the stop sign and make the next right into the parking lot.

For more information about Jefferson at the Navy Yard, call **1-800-JEFF-NOW** or visit us online at www.JeffersonHospital.org/navyard

