Amir Saffarian, M.D. Inc.
18181 Butterfield Blvd suite 185, Morgan Hill, CA 95037
Office: 408-779-2009 Fax:408-779-2011

_____Name
(First,Middle,Last) Male/Female Date of Birth SSN

_____
Home Address City Zipcode

_____
Home Number Cell Number Work Number E-Mail Address

_____
Marital Status Name of Spouse Preferred Language

Employer: Full Time/Part Time

Ethnicity (select one) Caucasian Hispanic African-American Middle Eastern Asian

_____
Nearest Friend/Relative (not living with you) Relationship Contact Number

Reminder call Preferance: Email Text message phone call

Family Physician_____ Phone
Other Physicians_____ Phone
IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)
Mother's Name_____Phone_____Date of Birth_____
Address_____SSN_____
Employer_____Phone_____
Father's Name_____Phone_____Date of Birth
Address_____SSN_____E
mployer_____Phone_____

PRIMARY INSURANCE:
Company Name_____
SECONDARY INSURANCE:
Company Name_____

WHICH PHARMACY DO YOU USE?
Name_____Phone#_____

WHICH LABORATORY DO YOU USE?
NAME: PHINE #_____.

AMIR SAFFARIAN, M.D. INC
FEMALE PATIENT QUESTIONNAIRE:
Name _____ Family Physician _____ Date_____
Reason for Visit -

Urinary Symptoms

	Yes	No
Burning on Urination	____	____
Frequent urination	____	____
Urgent need to urinate	____	____
Do you awaken at night to urinate	____	____
If yes, how many times	____	
Have you ever seen an urologist before?	____	____

_____

_____

Urinary Tract Infections	**Yes**	**No**
Have you ever had a prior urinary tract infection	____	____
If yes		
How many?	_____	
Last infection ?	_____	
Age infections started ?	_____	
Have you ever had a fever with infection?	____	____
Have you ever had pain in the back with infection? ____		____
Have you ever had X-rays of the kidney?	____	____
Were you ever hospitalized to treat an infection?	____	____
Have you ever had a sexually transmitted disease? ____		____

Incontinence

Do you leak urine with:	**Yes**	**No**
Coughing, Sneezing, walking?	____	____
Urgency, can't get to bathroom?	____	____
At night?	____	____
During sexual intercourse?	____	____
Do you use pads for protection?	____	____
If yes, how many? ____		
Do you have to strain to empty your bladder?	____	____
Have you ever had surgery for this reason?	____	____
If yes, please list date and Procedure/Surgeon	_____	

Kidney Stones	**Yes**	**No**
Do you have any pain in the back or abdomen?	____	____

Have you ever had a kidney stone before? ____ ____
If yes, when? _____
How many? _____
Passed on own? _____
Surgically removed? _____ What was the stone made of? _____

Did you have a work-up to determine the cause? ____ ____
Any prior dietary changes or medications? ____ ____
If yes, what?_____
_____

Hematuria	**Yes**	**No**
Have you ever seen blood in the your urine?	____	____
If yes, when? _____		
How many times? _____		
Did you have any pain or burning at the time?	____	____
Has a doctor ever found blood with a microscope?	____	____
Have you ever had prior work up for this problem?	____	____
If yes, when? _____		
What was done? _____		
What was found? _____		
Which urologist? _____		

Reproductive History	**Yes**	**No**
When was your last menstrual cycle _____		
Have you ever been pregnant?	____	_____
If yes, how many times? _____		
Are you currently pregnant?	_____	_____
How many children do you have? _____		
How many Cesarean Sections? _____		
Have you had a hysterectomy?	____	____
If yes, why and when? _____		

_____
Do you have pain with sexual intercourse? ____ ____

Medical History		
COPD	Breast cancer	Hypertension
GERD	Gout	Lung cancer
Prostate cancer	Skin cancer	Dementia
Bipolar disorder	Sleep apnea	Heart Attack
Autoimmune Disease	High Cholesterol	Diabetes mellitus
	Stroke	Other:

Surgical History

Surgery	Date	Surgeon
1.		
2.		
3.		

Medications

Name	Dosage	Directions

Please make sure to include and blood thinners (ie. Aspirin, plavix, coumadin, ibuprofen)

1._____
2._____
3._____
4;_____

Allergies **NO KNOWN DRUG ALLERGIES** ☐

Name of medication	Reaction
1.	
2.	
3.	

Family History (Include High blood pressure, diabetes cancer etc.)
(Also include prostate, kidney or bladder cancer or problems

Family Member	Age	Disease
1.Father		
2Mother		
3.		

Social History	Yes	No
Do you or have you ever smoked?	____	____
If yes, how much? _____packs/day		
How long? _____		
Have you quit? _____ If yes, when _____		
Do you drink alcohol?	____	____
If yes, how much? _____		
How long? _____		
Are you employed?	____	____
If yes, what type of work? _____		

Marital status _____ single, _____ married, _____ divorced

Do you drink caffeinated drinks?
(i.e coffee, energy drinks) _____ _____

TRAVEL HISTORY

HAVE YOU TRAVELED WITHIN THE LAST 30 DAYS? **YES** **NO**

HAVE YOU DEVELOPED ANY OF THE FOLLOWING SYMPTOMS WITHIN THE LAST 30 DAYS?

NONE FEVER RASH COUGH DIARRHEA

BODYACHE HEADACHE OTHER

HAVE YOU BEEN EXPOSED TO OR BEEN AROUND A SICK PERSON WITHIN THE LAST 30 DAYS? **YES** **NO**

SCREENING FORM

PHQ- Depression Screening

Little interest or pleasure in doing things?

YES **NO**

Feeling down, depressed or hopeless?

YES **NO**

PHQ-2 Depression Screening-*frequency of the following problems over the past two weeks*

Little interest or pleasure in doing things

0-not at all **1- Several days** **2- More than half the days** **3- Nearly every day** **4-**

Feeling down, depressed, or hopeless

0-not at all **1- Several days** **2- More than half the days** **3- Nearly every day**

Review of Systems

***Please underline which symptoms you have RECENTLY experienced.**

Constitutional (fevers, chills, headache)

_____

Integumentary (skin rash, itchiness, dryness, Boils)

_____

Eyes (blurred vision, Double vision pain in eyes,)

_____

Ears, nose and throat (Sore throat, ear infection, ear pain, hearing loss Sinus problems)

_____

Neurologic (tremors, dizzy spells, Numbness/tingling)

_____

Endocrine (tiredness, excessive thirst, too hot/cold)

_____

Heart (chest pain, heart attack, high blood pressure.)

_____

Lungs (shortness of breath, TB, asthma cough, wheezing.)

_____

Gastrointestinal (GERD, ulcers, hepatitis, abdominal pain, nausea, vomiting)

_____

Hematologic (Excessive bleeding, blood clots, lymphoma, anemia)

_____

Psychiatric (depression,anxiety, Mental illness)

_____

Musculoskeletal (Arthritis,GOUT, disc disease)

Social History
Please circle if any of these pertain to you:

Military Service	**Stress Concern**	**Seat Belt**	**Sleep Concern**
Blood Transfusion	**Weight Concern**	**Self- Exams**	**Bike Helmet**
Caffeine Concern	**Special Diet**	**Exercise**	
Occupational Exposure	**Back Care**	**Hobby Hazards**	

BLADDER SATISFACTION SURVEY

Which symptoms best describe you?

Frequent Urination – Day, Night, or Both
Sudden or Strong Urge to urinate
Unable to Empty the Bladder
Leaking with Sneezing, Coughing, Exercising
Leaking with Urge or No Warning
(Unable to make it to the bathroom in time)
Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

Detrol® LA	Ditropan XL®	Flomax®	Cardura®	Gelnique®
Oxytrol® Patch	Enablex®	VESIcare®	DDAVP®	Toviaz®

Sanctura® Elavil® Elmiron® Other_____

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief Completely Cured

If you've stopped taking your meds explain why:
Did not Help Side Effects Too Expensive

Describe Side Effects _____

Behavior Modifications Tried_____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated Very Frustrated

Do you currently have any problems with bowel function?: Fecal Incontinence
Constipation Other

I am interested in learning more about treatment alternatives to medications:
Yes No