Kidney Stone
— Center —
of the Rocky Mountains

EXTRACORPOREAL SHOCK WAVE

LITHOTRIPSY

(ESWL)

PATIENT QUESTIONNAIRE

This questionnaire is intended to provide the medical staff of the Kidney Stone Center of the Rocky Mountains with complete and accurate past and present medical history and related information. The first seven pages are to be filled out by the prospective patient and the final page must be completed by the referring physician or family physician.

Your detailed preparation of this form not only aids in establishing candidacy for Extracorporeal Shock Wave Lithotripsy but also promotes a safer treatment and more prompt recovery.

To expedite lithotripsy review and subsequent treatment, we request that this questionnaire accompany the x-rays at the time they are submitted to the Kidney Stone Center. This will assist the ESWL urologists in a more accurate and meaningful determination.

1721 East 19th Avenue, Suite 172, Denver, CO 80218 (303) 839-6060 FAX (303) 839-6377

IMPORTANT: The following requirements must be met before your Lithotripsy can be done!

The following medications contain ingredients which may interfere with your blood's ability to clot. These medications are either ASPIRIN-containing or ARTHRITIS medications. You must discontinue these one week prior to ESWL. Failure to do so will result in postponement of your surgery. This is a partial list and MAY NOT contain all medications. Please check with you primary care physician, urologist or the Kidney Stone Center (839-6060).

Please continue to take any other medications which you may be taking under the direction of your physician.

ACTABS
ADVIL
ALKA SELTZER
ALUPRIN
ANACIN
ANAPROX
ANTURANE
ANSAID
APS
ARTHRALGEN
ARTHRITIS PAIN
ASCRIPTIN
ASPERGUM
ASPIRIN
BAYER
BUFFERIN
BUTAZOLIDIN
CLINORIL
CODASA
COGESIC
COMEBACK
CONGESPRIL
COPE
CORICIDIN
COSPRIN
COUMADIN
DARVON COMPOUND
DAYPRO
DOLOR
DRISTAN
DURADYEN
DURAGESIC
DURAMED
ECOTRIN
EMPIRIN
ENCAPRIN
EQUAGESIC
EXCEDRIN
FELDENE
FENOPROFEN
FIORINAL
FORMAGESIC
IBUPROFEN
IMURINE
INDOCIN
INDOMETHACIN
LODINE
MEASURIN
MECLOMEN
MEPROBAMATE
MIDOL
MOTRIN
NABUMETON
NALFON
NAPROSYN
NORGESIC
NUPRIN
ORDUIS
OXYCODONE
OXPHENBUTAZONE
PAMPRIN
PERCODAN
PERSANTIN
PERSISTIN
PHENAPHEN
PEHNYLBATAZONE
PIROXICAM
PMS
PREMYSYN
PROPOXYPHENE
RELAFEN
RESOLVE
ROBAXISAL
ROXAPRIM
RUFEN
SINE-OFF
SODIUM SALCIYLATE
STANBACK
SYNALGOS
TALWIN COMPOUND
TANDEARIL
TORADOL
VANQUISH
VOLTAREN

REQUIRED LAB TESTS

The following lab work/tests must be done before treatment.

A: CBC* B: SMA7* C: Urine C&S* D: Pregnancy Test* E: EKG** F: H&P

* No older than 2 weeks pre-treatment.

** No older than 6 months pre-treatment. Required only if patient is over 50 or has significant medical history.

KIDNEY STONE CENTER OF THE ROCKY MOUNTAINS

PATIENT NAME: ____
Last First MI

Address: ____

City: ________________________ State: ____________ Zip: ____________

Home Phone: ________________________ SS# __________ - ________ - ______

Date of Birth: _____/_____/_____ Sex: __________

Height: __________________ Weight: ______________lbs Waist Size: ________

Religion: ____________________________ Race (optional): ________________

Marital Status: ________________ Spouse's Name (if applicable): ____________

Spouse's Birthdate: ______/______/______

Patient's Employer: ____

Address: ____
City State Zip

Occupation: ________________________ Date Employed: _____/_____/_____

Phone Number: ________________________ Extension: __________________

Nearest Relative (not living with you) who will know how to contact you in case of an emergency.

Name: ____________________________ Phone Number: ________________

Relationship to patient: ____

Referring Urologist's Name: ____

Phone Number: ____

INSURANCE INFORMATION

Policyholder Name:____

Address (if different from patient):_________________________________
City State Zip

Phone Number: (____)____

Date of Birth:_______/_______/_______ SS#:_______/______/________

Relationship to Patient:____

Employed By:____

Address:____
City State Zip

Occupation:_______________________ Date Employed:_____/_____/_____

Phone Number:_______________________ Extension:_________________

Insurance Company (Primary):_____________________________________

Address:____
City State Zip

Policy Number:_____________________ Group Number:________________

Benefit Phone Number:________________ Prior Auth. Phone:______________

Insurance Company (Secondary):___________________________________

Address:____
City State Zip

Policy Number:_____________________ Group Number:________________

Benefit Phone Number:________________ Prior Auth. Phone:______________

I directly assign all medical/surgical benefits to the above insurance company(s) for the Extracorporeal Shock Wave Lithotripsy and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:___________________________ Date:_____________________

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU

LITHOTRIPSY PRE-OPERATION MEDICAL INFORMATION

Please answer the following questions. (if you don't know an answer, please ask your physician or his/her assistant.)

YES	NO	
☐	☐	Have you ever had hypertension (high blood pressure)? If yes, when was it diagnosed?___________________
☐	☐	Do you take medication for hypertension now? If yes, what is the medication?___________________
☐	☐	Have you ever experienced bleeding problems such as hemophilia or internal bleeding? If yes, describe the problem(s)______________ ____ ____
☐	☐	Have you ever had pulmonary embolism (blood clots that pass to your lungs)?
☐	☐	Have you ever had phlebitis (inflammation of a vein)?

IMPORTANT!! YOU MUST STOP USING ASPIRIN PRODUCTS AND ANTICOAGULANTS (BLOOD THINING MEDICATION) ONE WEEK PRIOR TO LITHOTRIPSY TREATMENT.

What date did you stop taking aspirin products? _____/_____/_____

What date did you stop using anticoagulants? _____/_____/_____

YES	NO	
☐	☐	Are you allergic to any drugs? If yes, list them and date of last reaction:

	YEAR
________________________________	____________________
________________________________	____________________
________________________________	____________________
________________________________	____________________

OPERATIONS

List all operations you have had and approximate date(s):

Example: Left Hernia Repair 1987

______________________	______	______________________	______
______________________	______	______________________	______
______________________	______	______________________	______
______________________	______	______________________	______

CURRENT MEDICATIONS

List all drugs you are currently taking, including non-prescription drugs, such as vitamins. Give the number of tablets and number of times per day.

Remember: You must be off all aspirin, aspirin related products, and anticoagulants, for <u>one week</u> prior to treatment. Please carefully check the list on the pinks sheet to be sure you are not on these medications.

Example: Thyroid 3x/Day

______________________	______	______________________	______
______________________	______	______________________	______
______________________	______	______________________	______
______________________	______	______________________	______

LUNG PROBLEMS

YES	NO	
☐	☐	Do you have a history of lung problems? If yes, answer the following:
☐	☐	Do you have a history of emphysema? If yes, is it currently:____severe _____ mild?
☐	☐	Do you have a history of asthma? If yes, is it currently:____severe _____ mild?
☐	☐	Do you smoke? ______ packs per day.
☐	☐	Do you have other lung problems? If yes, please describe:________________________

HEART PROBLEMS

YES NO

- [ ] [ ] Do you have a history of heart problems? If yes, please answer the following questions:
- [ ] [ ] Do you require treatment for an irregular heart beat? If yes, list the medication(s): ____
____
- [ ] [ ] Have you had a heart attack? If yes, write the date(s) (month/year):
____
- [ ] [ ] Do you have angina (chest pain)? If yes, number of episodes per month:
____
- [ ] [ ] Have you had a by-pass operation? If yes, when?__________________
- [ ] [ ] Have you ever had heart failure? If yes, when?____________________
- [ ] [ ] Do you have a heart (cardiac) pacemaker?
- [ ] [ ] Do you have other heart problems? If yes, describe:________________
____
____

OTHER MEDICAL CONDITIONS

YES NO

- [ ] [ ] Are you now paralyzed? If yes, describe approximate level:_____________
- [ ] [ ] Do you have a history of diabetes?
- [ ] [ ] Do you have a history of cancer? If yes, complete the following:

Site/Location	Month/Year of Diagnosis
__________________________	____________________________
__________________________	____________________________
__________________________	____________________________

Women:

- [ ] [ ] Are you currently pregnant?
- [ ] [ ] Have you had a Tubal Ligation or Hysterectomy?

Please list any problems diagnosed that have not been listed on the previous pages.

Diagnosis	Date

STONE RELATED QUESTIONS

Do you have, or have you had, and of the following stone related diseases:

Yes	No	Unknown	
☐	☐	☐	Hyperparathyroidism (excessive parathyroid function)
☐	☐	☐	Hyperthyroidism (excessive thyroid function)
☐	☐	☐	Renal tubular acidosis (RTA)
☐	☐	☐	Sarcoidosis
☐	☐	☐	Hypercalcuria (excessive urinary calcium)
☐	☐	☐	Long-standing urinary infection
☐	☐	☐	Medullary sponge kidney
☐	☐	☐	Gout
☐	☐	☐	Intestinal Disease
☐	☐	☐	Immediate family history of kidney stones
☐	☐	☐	Osteoporosis
☐	☐	☐	Pathologic Fractures

Past Stone History:

☐ ☐ Have you had previous stones? If so, please answer the following:

Number passed spontaneously	Number Removed Surgically	Right or Left

☐ ☐ Have you been on any diet or medication to treat stones?

PHYSICAL EXAM/RADIOGRAPHIC REVIEW

PATIENT NAME:_________________________ **Date of Birth:**__________

Height_________ Weight_______ BP_______ Pulse_______ Temp_______

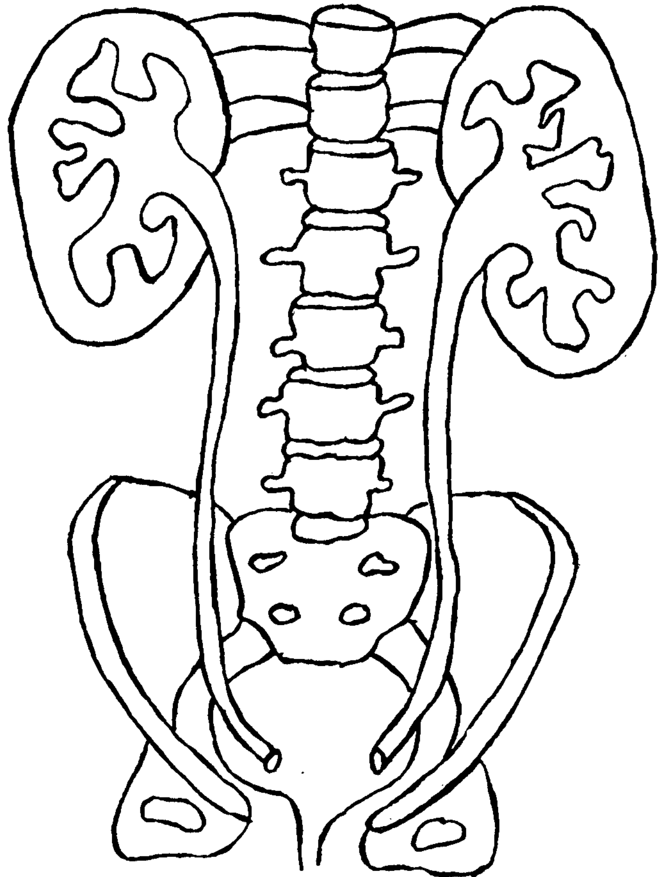
Patient is: ___ alert ___cooperative ___well informed
___ somnolent ___uncooperative ___not well informed

Physical Exam
(detail abnormalities)

		NORMAL	ABNORMAL
HEENT _________________	-- --	( )	( )
Neck_________________	-- --	( )	( )
Chest_________________	-- --	( )	( )
Heart_________________	-- --	( )	( )
Lungs_________________	-- --	( )	( )
Abdomen_________________	-- --	( )	( )
Penis/Urethra_________________	-- --	( )	( )
Scrotum/Testes_________________	-- --	( )	( )
Prostate: ____ grams; ___smooth	-- --	( )	( )
Pelvic_________________	-- --	( )	( )
Rectum_________________	-- --	( )	( )
Spine/Extremities_________________	-- --	( )	( )
Neurologic_________________	-- --	( )	( )

Additional Comments:

Stone Radiographics



These findings (including negatives) are reasonable and accurate summaries of my history, physical examination, and radiographic view.

____
MD Date

ALL PATIENS MUST BE OFF ASPIRIN AND BLOOD THINING PRODUCTS ONE WEEK PRIOR TO TREATMENT