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Urology

PATIENT INFORMATION

Name: ______________________________ Prefix: __________

Martial Status (please circle): **Single / Married / Partnered / Widowed / Divorced** Sex (please circle): **Male / Female**

Address: ______________________________ City/State/Zip: ______________________________

SS #: ______________ Home #: ______________ Cell #: ______________

Email Address: ______________________________

DOB: ___/___/___ Age: ______ Pharmacy Name: ______________ Street your pharmacy is on: ______________

Employer: ______________________________ Occupation: ______________________________

Employer Phone #: ______________ Employer Address: ______________________________

Primary Care Physician: ______________________________

Do you have power of attorney? **Yes / No** If yes, person's name: ______________ Person's #: ______________

Do you have a living will? **Yes / No**

SPOUSE *(if applicable)*

Name: ______________________________ DOB: ___/___/___ Phone #: ______________

EMERGENCY CONTACT

Name 1: ______________ Phone #: ______________ Relation: ______________

Address: ______________________________ City/State/Zip: ______________________________

Name 2: ______________ Phone #: ______________ Relation: ______________

Address: ______________________________ City/State/Zip: ______________________________

INSURANCE *(Please give your insurance card(s) to the receptionist)*

Primary Insurance: ______________ Policy #: ______________ Group #: ______________

Insured Name: ______________________________ DOB: ___/___/___ SS #: ______________

Employer: ______________________________ Relationship to insured (please circle): **Self / Spouse / Child / Other**

Secondary Insurance: ______________ Policy #: ______________ Group #: ______________

Insured Name: ______________________________ DOB: ___/___/___ SS #: ______________

Employer: ______________________________ Relationship to insured (please circle): **Self / Spouse / Child / Other**

REFERRAL INFORMATION

Referred By: ______________________________ Phone #: ______________

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TODAY'S DATE: ______ / ______ / ______

Please describe the reason for today's visit: ______________________

List Relevant Symptoms: ______________________

Are you allergic to any medications? **Yes** / **No** If yes, please list: ______________________

Please list all of your current medications, dosage, frequency, and the reason for taking them.

Medication	Dose	Frequency	Reason for taking

Are you taking any blood thinners?

- ❑ Aspirin
- ❑ Coumadin (Warfarin)
- ❑ Vitamin E
- ❑ Xeralto
- ❑ Plavix
- ❑ Fish Oil
- ❑ Pradaxa
- ❑ None

Do you smoke or use tobacco products? **Yes** / **No** If yes, how many packs per day? ________ How many years? ________

Do you drink alcoholic beverages? **Yes** / **No** If yes, how many drink per day? ________

Do you drink caffeine (soda, coffee, etc.)? **Yes** / **No** If yes, how many drink per day? ________

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PATIENT PAST MEDICAL HISTORY: Please list any medical conditions either current or past.

❑ Heart Disease	❑ Heart Attack	❑ Stroke
❑ Diabetes - On insulin? Yes / No	❑ Cancer (please specify type)	❑ Hypertensions (High Blood Pressure)
❑ High Cholesterol	❑ Prostate Cancer	❑ Depression
❑ Kidney Stones	❑ Kidney Disease	❑ Dialysis
❑ HIV/AIDS	❑ Parkinson's	❑ Alzheimer's
❑ Hepatitis: A / B / C	❑ Liver Disease	❑ Epilepsy or Seizures
❑ Other:		

PATIENT SURGICAL HISTORY: Please list any surgeries you have had and the year they were performed.

Surgery	Year of Surgery

FAMILY MEDICAL HISTORY: Please list any medical conditions in your family and specify which family member.

Condition	Family Member	Condition	Family Member
❑ Heart Disease		❑ Prostate Cancer	
❑ Diabetes		❑ Cancer (please specify type)	
❑ Stroke		❑ High Cholesterol	
❑ Alzheimer's		❑ Parkinson's	
❑ Heart Attack		❑ Kidney Disease	
❑ High Blood Pressure		❑ Dementia	
❑ Other: ________________		❑ Other: ______________	

Patient Name: ____ DOB: ____________________

Review of systems: Please check if you have any of these symptoms recently. **Please check NONE if none of the symptoms are present.**

General	**Eyes**	**Neurologic**	**Endocrine**
❑ Weight loss or gain ❑ Fever or chills ❑ Fatigue ❑ Headaches ❑ Sleep Apnea ❑ Other: ________ ❑ None	❑ Blurry or double vision ❑ Glaucoma ❑ Cataracts ❑ None	❑ Dizziness ❑ Fainting ❑ Numbness/Tingling ❑ Tremors ❑ Seizures ❑ Paralysis/Weakness ❑ None	❑ Excessive thirst ❑ Tired/Sluggish ❑ Too hot/cold ❑ None
Gastrointestinal	**Cardiovascular**	**Dermatological (Skin)**	**Musculoskeletal**
❑ Abdominal pain ❑ Nausea/Vomiting ❑ Stomach Ulcer ❑ None	❑ Chest pain or discomfort ❑ Heart trouble ❑ High blood pressure ❑ Shortness of breath ❑ Heart murmur ❑ Irregular heart beat ❑ None	❑ Rash ❑ Skin lumps ❑ Psoriasis ❑ None	❑ Muscle or joint pain ❑ Back pain ❑ Arthritis ❑ None
Ear/Nose/Throat/Mouth	**Respiratory**	**Hematological/Lymphatic**	**Psychiatric**
❑ Sinus problems ❑ Vertigo ❑ Hearing loss ❑ None	❑ Shortness of breath ❑ Asthma ❑ Frequent cough ❑ Coughing up blood ❑ Tuberculosis ❑ Wheezing ❑ None	❑ Swollen glands ❑ Blood clotting problems ❑ HIV ❑ None	❑ Depression ❑ Anxiety ❑ Suicidal thoughts ❑ None

FEMALE PREGNANCY HISTORY:

Number of Vaginal Deliveries: ______________________ Number of Caesareans: ______________________

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AUA SYMPTOM SCORE (AUASS)

Symptom Questions	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	SCORE
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5	
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 or more times**	
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
Total symptom score *(Add the score for each number above and write the total in the space to the right.)*							

SYMPTOM SCORE: 1–7 (Mild) 8–19 (Moderate) 20–35 (Severe)

QUALITY OF LIFE (QOL)

QOL Question	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Patient Name: ______________________ DOB: ______________

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THE IIEF-5 QUESTIONNAIRE (SHIM)

Over the past 6 months:						**SCORE**
How do you rate your confidence that you could get and keep an erection?	Very Low 1	Low 2	Moderate 3	High 4	Very High 5	
When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5	
During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5	
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5	
When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5	
Total symptom score *(Add the score for each number above and write the total in the space to the right.)*						

1–7: Severe ED
8–11: Moderate ED
12–16: Mild-moderate ED
17–21: Mild ED
22–25: No ED