

PLEASE PRINT CLEARLY

PATIENT INFORMATION

NAME _____	BIRTHDATE _____
SOCIAL SEC # _____	AGE _____
ADDRESS _____	SEX _____
CITY _____	MARITAL STATUS _____
STATE/ZIP _____	SPOUSE'S NAME _____
PHONE # _____	OCCUPATION _____
FAX # _____	_____
CELL # _____	_____

PRIMARY INSURANCE

SECONDARY INSURANCE

CARRIER _____	CARRIER _____
MEMBER # _____	MEMBER # _____
GROUP # _____	GROUP # _____
ADDRESS _____	ADDRESS _____
CITY/STATE/ZIP _____	CITY/STATE/ZIP _____
PHONE # _____	PHONE # _____

EMPLOYER INFORMATION

INSURANCE GUARANTOR

COMP. NAME _____	HOLDER NAME _____
ADDRESS _____	HOLDER SSN _____
CITY _____	HOLDER D.O.B. _____
STATE/ZIP _____	_____
PHONE # _____	_____
FAX # _____	_____

PHYSICIAN INFORMATION

FAMILY M.D. _____	REFERRING M.D. _____
PHONE # _____	PHONE # _____
FAX # _____	FAX # _____
ADDRESS _____	ONCOLOGIST _____
CITY _____	PHONE # _____
STATE/ZIP _____	FAX # _____

EMERGENCY CONTACTS

NAME _____	NAME _____
RELATIONSHIP _____	RELATIONSHIP _____
ADDRESS _____	ADDRESS _____
CITY _____	CITY _____
STATE/ZIP _____	STATE/ZIP _____
HOME PH # _____	HOME PH # _____
CELL PH # _____	CELL PH # _____
WORK PH # _____	WORK PH # _____
_____	_____

HEALTH QUESTIONNAIRE

PLEASE PRINT CLEARLY

Patient Name: _____ Date: _____

MEDICAL PROBLEMS

Problem (Onset Date) _____

Have you been diagnosed with lupus, rheumatoid arthritis, collagen vascular disease, or ulcerative colitis? _____

If so, do you take steroids such as prednisone? _____

SURGICAL PROCEDURES

Procedure and Date: _____

FAMILY HISTORY (Check appropriate answer)

	Alive	Age at Death, Cause of Death, Medical Problems (including Cancer)
Father	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Mother	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Son	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Daughter	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Other Relative	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

SOCIAL HISTORY (Check appropriate answer)

Smoking: No Yes
Frequency, number of years, years since quitting: _____

Alcohol Consumption: No Yes
Frequency, number of years, years since quitting: _____

Prior Radiation Therapy (site treated, name of center, date) _____

Occupation (if retired, previous occupation) _____

Marital Status and Number of Children _____

City Where You Currently Live _____

ALLERGIES

Drug and Response (Example: Penicillin results in hives) _____

REVIEW OF SYSTEMS

Do you have the following?

General

Relatively good health most of your life No Yes
 Weight change over past 6 mos. +/- lbs. No Yes

Skin

Serious skin problems No Yes
 Jaundice No Yes
 Hives, rashes, or eczema No Yes
 Infections or boils No Yes
 Unusual pigmentation No Yes

Head

Serious headaches or injuries No Yes

Eyes

Glasses No Yes
 Condition: _____
 Serious eye diseases or injuries No Yes
 Double vision No Yes
 Glaucoma No Yes

Ears, Nose and Throat

Runny Nose No Yes
 Nosebleeds No Yes
 Impaired hearing No Yes
 Dizziness or episodes of unconsciousness No Yes
 Throat Problems No Yes

Respiratory

Spitting up blood No Yes
 Chronic cough No Yes
 Asthma or wheezing No Yes
 Shortness of breath No Yes
 Pleurisy or pneumonia No Yes

Neck

Thyroid illnesses No Yes
 Glandular enlargement No Yes

Cardiovascular

Chest pain or angina pectoris No Yes
 Shortness of breath while resting No Yes
 Heart trouble or heart attacks No Yes
 Date(s): _____
 High blood pressure No Yes
 Swelling of hands, feet or ankles No Yes
 Other known heart disease No Yes
 Specify: _____

Gastrointestinal

Peptic ulcer (stomach or duodenal) No Yes
 Vomiting blood No Yes
 Liver trouble No Yes
 Hepatitis; if yes A, B, or C (circle one) No Yes
 Painful bowel movements No Yes

Gastrointestinal (cont'd)

Bleeding with bowel movements No Yes
 Heartburn or indigestion No Yes
 Cramping No Yes
 Trouble swallowing No Yes
 Black stools No Yes
 Hemorrhoids or piles No Yes
 Recent change in bowel habits No Yes
 Frequent diarrhea No Yes
 Regular bowel movements No Yes

Gynecological (if applicable)

Gynecological problems No Yes
 Currently pregnant No Yes
 Date of last pregnancy test _____
 Age when periods started _____
 Age at first delivery _____
 Number of pregnancies _____
 Number of miscarriages _____
 Age when periods ended _____
 Menopause reason, e.g. surgery _____
 # yrs of contraceptive hormone use _____
 # yrs of postmenopausal hormone use _____
 Date and results of last pap smear _____

 Date and results of last mammogram _____

Musculoskeletal

Arthritis; (Circle: osteo or rheumatoid) No Yes
 Muscle-joint weakness or diseases No Yes

Neurological

Fainting spells No Yes
 Convulsions No Yes
 Paralysis No Yes
 Strokes No Yes
 Head injuries No Yes
 Seizures No Yes

Hematological

Bruise easily or heal slowly No Yes
 Blood disease No Yes
 Anemia No Yes
 Phlebitis No Yes
 Unusual bruising No Yes
 Bleeding with injuries or dental work No Yes

Psychiatric

Psychiatric history No Yes

Endocrine

Hormonal problems No Yes
 Endocrine problems No Yes

AUA SYMPTOM SCORE

Last Name: _____ First Name: _____ Date: _____

Highlight, bold, or circle your response and type or write in your score in the far right box for all SEVEN questions.

1. Incomplete emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

2. Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you previously urinated?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

3. Intermittency: over the past month, how often have you found that you stopped and started again several times when you urinated?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

4. Urgency: Over the past month, how often have you found it difficult to postpone urination?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

5. Weak Stream: Over the past month, how often have you had a weak stream?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

6. Straining: Over the past month, how often have you had to push or strain to begin urination?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

7. Nocturia: Over the past month, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

Not at all	1 time	2 times	3 times	4 times	5 or more times	Your score
0	1	2	3	4	5	

Add up your scores for total AUA Score: _____

8. Quality of Life Due to Urinary Symptoms: If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?

Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible

SEXUAL HEALTH INVENTORY FOR MEN

(Please fill this out independently of your partner)

PATIENT NAME: _____ **DATE:** _____

INSTRUCTIONS:

Sexual health is an important part of an individual’s overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle or bold the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	No Sexual Activity	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory to you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to Questions 1-5

TOTAL: _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED

8-11 Moderate ED

12-16 Mild to Moderate ED

17-21 Mild ED

SEXUAL HEALTH INVENTORY FOR MEN
(Please have your partner fill this out independently of you)

NAME: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

INSTRUCTIONS:

Sexual health is an important part of an individual’s overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help your partner and his doctor identify if he may be experiencing erectile dysfunction.

Each question has several possible responses. Circle or bold the number of the response that best describes your partner’s situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your partner’s confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When your partner has had erections with sexual stimulation, how often were his erections hard enough for penetration?	No Sexual Activity	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often was your partner able to maintain his erection after penetration?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain his erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory to you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to Questions 1-5

TOTAL: _____

