Patient Name:____DOB:____________________ Email:_____

Phone Number:____

Procedure: **GAINSWave®** **GAINSWave® + Gaines Enhancement®**

Primary Goal**: Erectile Performance** **ED** **Peyronie's**

Medical History**: DM** **HTN** **CVD**

Current Med Use**: Beta-Blockers** **SSRIs** **PDE5i [Cialis, Viagra, Levitra]**

Prior use of PDE5i: **(circle one) YES** **NO** PDE5i Response**: None / Poor / Good**

The Erectile Hardness Score [*choose one*]

1. Penis is larger, but not hard
2. Penis is hard, but not hard enough for penetration
3. Penis is hard enough for penetration, but not completely hard
4. Penis is completely hard and fully rigid

SHIM

1. How would you rate your confidence that you can get and keep an erection? _____
1=very low 2=low 3=moderate 4=high 5=very high

2. When you have erections with sexual stimulation, how often are your erections hard enough for penetration? ___
1=never 2=a few times 3=sometimes 4=most times 5=always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner? __________________
1=never 2=a few times 3=sometimes 4=most times 5=always

4. During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse? ___
1=extremely difficult 2=very difficult 3=difficult 4=slightly difficult 5=not difficult

5. When you attempt sexual intercourse, how often is it satisfactory for you? _________
1=never 2=a few times 3=sometimes 4=most times 5=always

For office use only:

RESULTS

Follow up: DATE:____/

______/______ Erectile Hardness Score _______

SHIM Total Score_____

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

Patient demographic information

DATE: ______________________

LAST NAME: ____ FIRST: ___________________________ MI: ________

DOB: _____/_____/________ SOC SECURITY #: ______-______-__________ SEX: MALE / FEMALE

ADDRESS: ____

CITY: ______________________________________ STATE: _____________ ZIP: ____________

PHONE #: HOME: _______________________ CELL: ______________________

Number you prefer for us to contact you: _____ Home or _____ Cell

EMAIL: ____

ETHNICITY/RACE:

____ Caucasian
____ African American
____ Hispanic/Latino
____ Asian
____ Native American
____ Pacific Islander
____ Middle Easterner
____ Other

RETIRED / DISABLED / EMPLOYED: EMPLOYER: _______________________________________

OCCUPATION: ____ MARITAL STATUS: S / M / D / W / OTHER

EMERGENCY CONTACT: ___________________________________RELATION: ___________ PHONE: _________________

EMERGENCY CONTACT: ___________________________________RELATION: ___________ PHONE: _________________

PREFERRED PHARMACY(S): ____ CITY/PHONE: ________________________

PREFERRED PHARMACY(S): ____ CITY/PHONE: ________________________

INSURANCE INFORMATION

Primary Insurance: _________________________________ Secondary Insurance: ________________________________

Policy #: ___________________________________ Policy #: ____________________________________

Insurance Authorization/Financial Responsibility and patient notice

I hearby authorize payment directly to Family Practice of Suntree and Viera, P.A for services rendered and remain in effect until revoked in writing. I understand that my insurance policy is a contact between myself and my insurance provider and I agree to be financially responsible for non-covered services. I understand that I am ultimately responsible for ALL charges whether or not covered by my insurance company or policy and any co-payments, co-insurance or deductibles amounts not covered by my insurance is my financial responsibility. My insurance claim is billed by Family Practice of Suntree and Viera, P.A. as a courtesy and any of my financial responsibility is **due at the time of service.**

I understand that it is my responsibility to know and understand my benefits, coverage, participating labs, hospitals, diagnostic centers and pharmacies. I hereby authorize Family Practice of Suntree and Viera, P.A to release any information/medical records regarding my treatment to my insurance company to secure payment for services rendered. I have provided current and accurate information.

Signature: ____ Date: ________________
(Patient, parent or legal guardian if minor)

Relationship to patient if signed by personal representative: ____

Health History Questionnaire

NAME: ____ **D.O.B.** ____________________ **DATE:** __________________

Medical History:

Please list all **P** for Past and **C** for current medical problems.

___ Anemia	___ COPD	___ Liver Disorders (Hepatitis)	___ Arthritis
___ Anxiety	___ CVA/Stroke	___ Hypothyroid	___ Osteoporosis
___ Asthma	___ Depression	___ HIV	___ Stomach ulcers
___ Blood transfusion	___ Emphysema	___ High cholesterol	___ Pneumonia
___ Enlarged Prostate	___ Gallstones	___ High blood pressure	___ Kidney failure
___ Borderline diabetic	___ Glaucoma	___ Kidney stones	___ Seizure disorder
___ Coronary Artery disease	___ Gout	___ Leukemia	___ Memory loss
___ Cataracts	___ Heart disease	___ Migraine headaches	___ Thyroid disorder
___ Congestive heart failure	___ Heart attack	___ Diabetes:non-insulin dependent	___ Low testosterone
___ Neuropathy	___ Shortness of breath	___ Diabetes: insulin dependent	___ Tobacco abuse
___ Atrial Fib/Arrhythmia	___ Blood clot/DVT	___ Reflux/GERD	___ Back pain
___ Cancer: type ____________________________		___ Diverticulosis	___ Dizziness

Allergies: ____

Previous Surgeries:	**Year**	**Hospitalizations/Reason:**	**Year**
____		____	
____		____	
____		____	
____		____	

Family History:

Father: Living / Deceased DOB: ______ History: ____

Mother: Living / Deceased DOB: ______ History: ____

Any one in your family with a history of high blood pressure, diabetes, heart disease, stroke, seizures or Cancer? (example:sister/high blood pressure, mother/stroke, maternal grandma/cancer) _________________

____

____

Social History:

Alcohol:

Do you drink alcohol? Yes or No

Drinks per day:

Beer _____ Wine _____ Hard Liquor _____

Occupation: __________________________

Smoking or Tobacco Use:

Have you ever smoked? Yes or No

Are you still smoking? Yes or No

Packs per day ________

How many years? ________

Quit in what year? ________

Year of last tetanus shot? ________ Last Flu shot? ________ Last pneumonia shot? ________

Review of systems: Please check off any recent or new problems that apply to your health

General Health:
___ Fatigue
___ Poor appetite
___ Fevers or chills
___ night sweats

Head & Neck
___ Headaches
___ Dizziness
___ Lightheaded
___ Trauma
___ Blacking out

Ear, Nose & Throat
___ eye pain
___ blurred/double vision
___ sore throat
___ sinus/throat pain
___ hearing loss
___ ringing in ears
___ excess ear wax

Skin
___ rash
___ lesions/sores
___ easy bruising
___ dry skin

Endocrine/Hormones
___ hot flashes
___ hair loss
___ sexual dysfunction
___ heat/cold intolerance

Cardiac/Heart
___ chest pain
___ shortness of breath
___ palpitations
___ fatigue w/exercise
___ general swelling

Pulmonary/Lungs
___ shortness of breath
___ cough
___ wheezing
___ bloody sputum

Digestive/Abdomen
___ heartburn
___ nausea/vomiting
___ diarrhea
___ constipation
___ bloody stools
___ black tarry stools
___ abdominal pain

Urinary/Genital
___ painful urination
___ blood in urine
___ discharge or lesion
___ urinary frequency
___ incontinence
___ STD exposure

Joints/Muscle
___ back pain
___ joint pain
___ muscle pain
___ swelling/edema
___ muscle spasms
___ numbness/tingling

Neurological
___ neuropathy
___ loss of consciousness
___ seizures
___ muscle weakness
___ dizziness
___ focal deficits
___ loss of balance
___ slurred speech

Medications: Please list all medications, vitamins and supplements that you are currently taking.

Name:	Dose (mg)	Reason for taking
________________________	__________	________________________
________________________	__________	________________________
________________________	__________	________________________
________________________	__________	________________________
________________________	__________	________________________
________________________	__________	________________________