PRIME HealthCare, PC

Patient Demographic Form

www.primehc.com

Patient Last Name	Patient First Name	MI	Date of Birth	SEX ☐ Female ☐Male ☐ Other: _____

Social Security #	Email Address	Marital Status ☐S ☐M ☐D ☐W

Employment Status: ☐Employed ☐Retired ☐Self-Employed ☐Part-Time Student ☐Full-Time Student ☐Disabled ☐Unemployed

The Federal Government asks providers to ask the questions below.

Race	Ethnicity	Language
☐Caucasian ☐Black ☐Asian ☐Native Indian / Native Alaskan ☐Native Hawaiian / Pacific Islander ☐ Other Race ☐Unknown	☐Hispanic/Latino ☐Not Hispanic/Latino ☐Caucasian ☐Other ☐Unknown	☐English ☐Spanish ☐French ☐Polish ☐Vietnamese ☐Sign ☐Other

Home Address	City	State	Zip Code

Billing / Mailing Address	City	State	Zip Code

Preferred Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No	Additional Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No	Additional Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No

Employer	Employer Address	City	State	Zip Code

Primary Care Provider:	**Referring Physician:**	**Ophthalmologist:**
Primary Insurance Coverage Name	Insurance ID #: _____ Group #: _____	Effective Date: _____
Subscriber: ☐Patient ☐Spouse ☐Parent ☐Other Subscriber Name:	Date of Birth: _____ Social Security #: _____	Employer:
Secondary Insurance Coverage Name	Insurance ID #: _____ Group #: _____	Effective Date: _____ Copay $: _____ Deductible: _____
Subscriber: ☐Patient ☐Spouse ☐Parent ☐Other Subscriber Name:	Date of Birth: _____ Social Security #: _____	Employer:

Emergency Contact	Relationship to Patient: ☐ Wife ☐Husband ☐Child ☐Parent ☐Friend ☐Guardian ☐Other Name: Contact Phone: Work Phone:

I hereby authorize direct payment to medical/surgical benefits to Prime Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me above is correct. I hereby authorize Prime Healthcare, PC, its agents and representatives, to access information regarding my person, whereabouts, and to release all necessary information to my insurance company regarding my medical history, examinations, and treatments for the purposes of processing my insurance claims. A photocopy of my signature is valid as the original.

Signature: _____ Date: _____

PARENT / GUARDIAN INFORMATION

Relationship to Patient: ☐Parent ☐Guardian ☐Brother/Sister ☐Power of Attorney ☐Other

Name:	Social Security #:	Date of Birth:	Contact #:

PHARMACY NAME/ADDRESS: **Phone Number:**

PRIME HealthCare, PC

Greater Hartford Urology Group
19 Woodland Street
Hartford, CT 06105
P: 860-522-2251 F: 860-493-2552

Name: _____
DOB: _____ Age: _____
Height: _____ Weight: _____

ROS – Check the conditions/diseases you have currently or have had in the past:

GENERAL:
____ Pneumonia
____ Heart Disease
____ Arthritis
____ Tuberculosis
____ Diabetes
____ Cancer
____ Glaucoma
____ Hernia
____ Transfusions
____ Back pain
____ Hypertension
____ Asthma
____ AIDS/HIV
____ Bronchitis
____ Stroke
____ Hepatitis
____ Ulcer
____ Kidney Stones
____ Thyroid Disease
____ Bleeding Disorder

CONSITUTIONAL:
____ Weight loss/gain
____ Change in Appetite

HENT:
____ Hearing loss
____ Glaucoma
____ Cataracts

RESPIRATORY:
____ Shortness of Breath
____ Wheezing

GASTROINTESTINAL:
____ Cramping
____ Chronic Diarrhea
____ Constipation
____ Rectal Bleeding

CARDIAC/VASCULAR:
____ Palpitation
____ Chest Pain
____ Arrythmia/AFIB

GENITOURINARY:
____ Frequent AM Urination
____ Frequent PM Urination
____ Painful Urination
____ Leakage of Urine
____ Blood in Urine
____ Back Pain
____ Kidney Infection
____ Kidney Stones
____ Urinary Urgency
____ Urinary Retention
____ UTI's
____ Weak Stream
____ Urological Cancer
____ Prostate Cancer

INTEGUEMTARY:
____ Skin Rash

NEUROLOGICAL:
____ Dizziness
____ Seizures
____ Lightheaded
____ Tremor

ENDOCRINE:
____ Hot/Cold Flashes
____ Hair Loss

MUSCLOSKEELETAL:
____Back Aches

PSYCHOLOGICAL
____ Depression
____ Memory Loss

WOMEN ONLY:
____ Birth Control
____ LMP
____ Pregnancies

MEN ONLY:
____ Penile Discharge
____ Testicular lump/pain
____ Impotence
____ Painful Intercourse

Current Medications: _____
_____
Allergies to Medications:_____
_____
Surgeries: _____
_____

Family History:
Mother _____ PGF _____
Father _____ MGM _____
PGM _____ MGF _____

Social History:
Current Smoker: Y or N If so, how much per day ¼ pack, ½ pack, ¾ pack, 1 pack or 2 pack
Alcohol: Y or N If so , how much per week _____
Elicit Drug Use: Y or N If so please list _____

International Prostate Symptom Score (IPSS)

Patient Name: Date of Birth: Today's Date:

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times 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?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:		+	+	+	+	+

Total International Prostate Symptom Score = _____

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

Sexual Health Inventory for Men (SHIM)

Instructions

Each question has five possible responses. Circle the number that best describes your own situation. Select only one answer for each question.

Over the last six months:

1. How do you rate your confidence that you could keep an erection?

1	2	3	4	5
Very low	Low	Moderate	High	Very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

1	2	3	4	5
Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (more than half the time)	Almost always or always