Name: ___________________________ **Date:** _______________

DOB: ___________

Welcome to our office or welcome back. We want to provide you with the best possible care, so please take a few moments to complete the following pages. Thank you.

What is the main urologic issue you would like to discuss?

____
____
____

Do you have any other urologic issues you would like addressed?

____
____
____

Please list any medical conditions you have (high blood pressure, diabetes, etc.:

1. _____________________________________ 4. _____________________________________
2. _____________________________________ 5. _____________________________________
3. _____________________________________ 6. _____________________________________

Please list any prior surgeries or procedures: **Date of surgery/procedure:**

1. _____________________________________ _____________________________________
2. _____________________________________ _____________________________________
3. _____________________________________ _____________________________________
4. _____________________________________ _____________________________________

Name: ___________________________

DOB: ___________________

Please list any current medications/herbal supplement:	**Dose:**
1. ____	___________________________________
2. ____	___________________________________
3. ____	___________________________________
4. ____	___________________________________
5. ____	___________________________________
6. ____	___________________________________
7. ____	___________________________________
8. ____	___________________________________
9. ____	___________________________________
10. ____	___________________________________

Please list any medications you are allergic to:	**Reaction:**
1. ____	___________________________________
2. ____	___________________________________
3. ____	___________________________________
4. ____	___________________________________

Please list any serious illness in your family:

Relative: ____	Illness: ____________________________
Relative: ____	Illness: ____________________________
Relative: ____	Illness: ____________________________

Name: ___________________________

DOB: ____________________

MALE PATIENTS ONLY:

Do you have difficulty achieving or maintaining an erection?	Yes ☐	No ☐
Have you ever had an abnormal PSA result?	Yes ☐	No ☐
Ave you every had a prostate biopsy?	Yes ☐	No ☐
If yes, please list biopsy date(s) and result(s): _______________________________		
Ashkenazi Jewish Ancestry?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with metastatic prostate cancer?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with ovarian cancer?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with pancreatic cancer?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with breast cancer <50 years old?	Yes ☐	No ☐
Have you or any one in your family been diagnosed with any other type of cancer(s)? If yes, please indicate what type: _______________________________	Yes ☐	No ☐

****

Please indicate your current marital status:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

On average, how many alcoholic beverages do you have in a week? _____________________________

Did you ever smoke on a regular basis? Yes ☐ No ☐

If yes, how many packs a day? ________________ For how many years? _________

Are you still smoking? Yes ☐ / No ☐ If no, when did you quit? _____________

Have you had a colonoscopy in the last 5 years? Yes ☐ / No ☐

Do you have an Advanced Care Plan in place? Yes ☐ / No ☐ /No ☐ (my cultural and/or spiritual beliefs preclude me from having a discussion regarding advance care planning)

If yes… ☐ Living Will ☐ Do Not Resuscitate ☐ Power of Attorney

REVIEW OF SYSTEMS

Do you or have you recently had any problems related to the following?
Please circle **Y** for Yes or **N** for No. If your answer is Yes, please explain in the space provided.

Name: ___________________________________ **DOB:** ______________

Constitutional

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N
Other __________________________		

Eyes

Blurred vision	Y	N
Glaucoma	Y	N
Other __________________________		

Ears/Nose/Throat

Difficulty hearing	Y	N
Sinus problems	Y	N
Difficulty swallowing	Y	N
Other __________________________		

Respiratory

Shortness of breath	Y	N
Chronic cough	Y	N
Other		

Cardiovascular

Chest pain	Y	N
Heart attack	Y	N
High blood pressure	Y	N
Other __________________________		

Genitourinary

Frequent urination	Y	N
Wake to urinate	Y	N
# of times _______		
Slow stream	Y	N
Push to urinate	Y	N
Retaining urine	Y	N
Painful urination	Y	N
Urinary tract infection	Y	N
Incontinence	Y	N
# of pads per day _______		
Sexual activity	Y	N
Low libido	Y	N
Erectile dysfunction	Y	N
Premature ejaculation	Y	N
Difficulty reaching orgasm	Y	N
Other __________________________		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Constipation/diarrhea	Y	N
Other __________________________		

Musculoskeletal/Neck

Back pain	Y	N
Leg pain	Y	N
Muscle pain	Y	N
Other __________________________		

Neurological

Migraines	Y	N
Dizzy spells (Lightheadedness)	Y	N
Numbness/tingling	Y	N
Other __________________________		

Integumentary

Skin rash	Y	N
Skin lesion(s)	Y	N
Breast (lumps, etc.)	Y	N
Other __________________________		

Allergic/Immunologic

Hay fever	Y	N
Environmental allergies	Y	N
Food allergies	Y	N
Other __________________________		

Hematologic/Lymphatic

Blood clotting disorder	Y	N
Anemia	Y	N
Swollen glands	Y	N
Other __________________________		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other __________________________		

Psychological

Depression	Y	N
Anxiety	Y	N
Other __________________________		

____ ______________________________

Physician Signature Date

URINARY SYMPTOM SCORE

_____________________________ _____________________________ _________________
Last Name **First Name** **Date**

From the scale 0 to 5, please circle the number that best describes your response for each question and fill in your score in the far-right box for all SEVEN questions.

1. **Incomplete emptying:** Over the past months(s) how often have you had the sensation of not emptying your bladder completely after you finished urinating?

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	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 finished urinating?

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	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 time in 5	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 time in 5	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 time in 5	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 time in 5	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 or so, 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 score for total AUA score= _________

Quality of Life Due to Urinary Symptoms: 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? Please circle your answer below.

Delighted	**Pleased**	**Mostly satisfied**	**Mixed**	**Mostly dissatisfied**	**Unhappy**	**Terrible**

Patient Name: ___________________

THE IIEF-5 QUESTIONNAIRE (SHIM)

Please circle the response that best describes you for the following five questions.

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?

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

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

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

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

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

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

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

Total Score: ____________

1-7	*8-11*	*12-16*	*17-21*	*22-55*
Severe ED	*Moderate ED*	*Mild-moderate ED*	*Mild ED*	*No ED*