



Last Name _____ First Name _____

Date of Birth: ___/___/___ Social Security Number: _____

Referring Physician: _____ Phone #: _____

Physician Address: _____

History of Present Illness

Please answer the following questions

Chief Complaint

What is the main reason for your visit today?

- Prostate Cancer
- Urinary Tract Infections
- Renal Cyst/ Mass
- BPH (Enlarged Prostate)
- Erectile Dysfunction
- Testicular/Scrotal Swelling/Pain
- Urinary Frequency
- Other: _____
- Bladder Cancer
- Hematuria (Blood in Urine)
- Kidney Stones
- Elevated PSA
- Vasectomy
- Infertility
- Urinary Incontinence

1. Which symptoms best describe you? Check all that apply.

- Frequent Urination—day, night, or both
- Sudden or strong urge to urinate
- Leakage with little or no warning----sometimes unable to make it to the bathroom in time
- Unable to completely empty the bladder-----feels like there is more even after going to the bathroom
- Accidental leakage with physical activity---exercising, sneezing, or coughing
- Bladder or pelvic pain
- Problems with bowel function (if checked, please select symptom below)
 - Accidental loss or leakage of stool
 - Constipation
 - Other
- Erectile Dysfunction (if checked please skip and continue to Erectile Dysfunction Questionnaire)

Have you tried medications to help your bladder symptoms? Yes No

If yes, how many different medications have you tried? _____

Are you still taking any of these medications? Yes No

If no, why have you stopped taking them?

- Did not work as well as expected
- Interaction with other medications
- Side effects
- Expense
- Other

If side effects or other checked, please explain: _____

Behavior modifications tried? _____

(I.e., reduced fluid intake, caffeine reduction, Kegel exercises, physical therapy, or lifestyle changes)

IPSS Symptom Score

(Bubble ONE number on each line)	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
INCOMPLETE EMPTYING Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
FREQUENCY During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
INTERMITTENCY During the past month or so, how often have you found you stopped and started again several times when you urinated?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
URGENCY During the past month or so, how difficult have you found it to postpone urination?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
WEAK STREAM During the past month or so, how often have you had a weak urinary stream?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
STRAINING Over the past month, or so have you had to push or strain to begin urination?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
	None	1 Time	2 Times	3 Times	4 Times	5 or more Times
NOCTURIA Over the past month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

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



Erectile Dysfunction

(BUBBLE in ONE number on each line)						
How <u>often</u> were you able to get an erection during sexual activity?	No sexual activity <input type="radio"/> 0	Almost never or never <input type="radio"/> 1	A few times (much less than half the time) <input type="radio"/> 2	Sometimes (about half the time) <input type="radio"/> 3	Most times (much more than half the time) <input type="radio"/> 4	Almost always or Always <input type="radio"/> 5
When you had erections with sexual stimulation, how often were your erections <u>hard enough</u> for penetration?	No sexual activity <input type="radio"/> 0	Almost never or never <input type="radio"/> 1	A few times (much less than half the time) <input type="radio"/> 2	Sometimes (about half the time) <input type="radio"/> 3	Most times (much more than half the time) <input type="radio"/> 4	Almost always or Always <input type="radio"/> 5
When you attempted sexual intercourse, how often were you able to <u>penetrate</u> (enter) your partner?	Did not attempt intercourse <input type="radio"/> 0	Almost never or never <input type="radio"/> 1	A few times (much less than half the time) <input type="radio"/> 2	Sometimes (about half the time) <input type="radio"/> 3	Most times (much more than half the time) <input type="radio"/> 4	Almost always or Always <input type="radio"/> 5
During sexual intercourse, were you able to <u>maintain</u> your erection after you had penetrated (entered) your partner?	Did not attempt intercourse <input type="radio"/> 0	Almost never or never <input type="radio"/> 1	A few times (much less than half the time) <input type="radio"/> 2	Sometimes (about half the time) <input type="radio"/> 3	Most times (much more than half the time) <input type="radio"/> 4	Almost always or Always <input type="radio"/> 5
During intercourse, <u>how difficult</u> was it to maintain your erection to <u>completion</u> of intercourse?	Did not attempt intercourse <input type="radio"/> 0	Extremely difficult <input type="radio"/> 1	Very difficult <input type="radio"/> 2	Difficult <input type="radio"/> 3	Slightly difficult <input type="radio"/> 4	Not difficult <input type="radio"/> 5
How do you rate your <u>confidence</u> that you could get and keep an erection?		Very Low <input type="radio"/> 1	Low <input type="radio"/> 2	Moderate <input type="radio"/> 3	High <input type="radio"/> 4	Very High <input type="radio"/> 5

Add the score for each number ABOVE and write the total in the space to the right: _____

Sexual aids used regularly (bubble in all that apply):

- None Pills (e.g. Viagra) Muse Injections Vacuum device Penile Prosthesis

Past Medical & Social History



Please answer the following questions

Medical History

Please check if **you** have ever had any of the following:

- Parkinson's
 - Heart Disease
 - High Blood Pressure
 - High Cholesterol/triglyceride
 - Stroke/TIA
 - Thyroid
 - Cancer: Type _____
 - Kidney/Bladder (Renal Cyst, Renal Mass, Stones)
 - Anxiety, depression or mental illness
 - Blood disorders (abnormal bleeding anemia, high or low white count)
 - Other _____
- Multiple Sclerosis
 - Heart Attack
 - Lung (COPD, Asthma)
 - Sexually transmitted disease
 - Diabetes
 - Seizures/Epilepsy

Surgical History

- Have you ever had surgery? Yes No
- Please list approximate dates and reasons for any surgery (including childbirth):

Date	Surgeries
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications

- Please list any prescription medications you are currently taking and their dosages.
- Please indicate if you are taking of the following over the counter medications:

Medication Name	Dosage	Reason for taking

- Aspirin
- Tylenol
- Advil/Motrin/Ibuprofen

Medications cont.

- Antacid
- Laxatives
- Decongestants
- Antihistamines
- Vitamins/Mineral Supplements
- Other: _____

Pharmacy

Pharmacy Name: _____
 Pharmacy Address: _____
 Pharmacy Phone Number: _____

Allergies

Do you have any allergies? Yes No
 If yes please specify below:

Social History

Occupation: _____
 Marital Status: Single Married Divorced Widow
 Do you smoke? Yes No
 How much? _____
 Have you smoked in the past? Yes No
 How Long? _____
 Do you drink alcohol? Yes No How Much?
 Beer _____
 Wine _____
 Liquor _____
 Do you drink Caffeine? Yes No How Much?
 Coffee _____
 Tea _____
 Soda _____
 Are you on a special diet? Yes No
 If yes please Specify: _____

Family History

Please list all serious illnesses in your immediate family;
 (Example: Diabetes, Cancer, Tuberculosis, Heart disease)

Mother: Age _____ Living: _____
 Deceased-Cause: _____
 Father: Age _____ Living: _____
 Deceased-Cause: _____
 Sister: _____
 Brother: _____



Review of symptoms

Are you currently having problems with the following? Circle yes (y) or no (N)

Constitutional Symptoms

Fever	Y N
Chills	Y N
Sweats	Y N
Weakness	Y N
Fatigue	Y N

Eyes

Blurred Vision	Y N
Double Vision	Y N
Pain	Y N

Immunologic

Recurrent Fevers	Y N
Recurrent Infections	Y N
Malaise	Y N

Neurological

Confusion	Y N
Numbness/Tingling	Y N
Dizzy Spells	Y N
Headache	Y N

Endocrine

Excessive Thirst	Y N
Too hot/Cold	Y N
Excessive Hunger	Y N

Gastrointestinal

Abdominal Pain	Y N
Nausea/Vomiting	Y N
Indigestion/heartburn	Y N
Diarrhea	Y N

Cardiovascular

Chest Pain	Y N
Palpitations	Y N
Ankle Swelling	Y N

Integumentary

Skin Rash	Y N
Boils	Y N
Persistent itch	Y N
Burns	Y N
Skin Lesion	Y N

Musculoskeletal

Joint pain	Y N
Neck Pain	Y N
Back Pain	Y N

Ears/Nose/Throat/Mouth

Ear Infection	Y N
Sore Throat	Y N
Sinus Problems	Y N

Genitourinary

Urine Retention	Y N
Painful Urination	Y N
Urinary Frequency	Y N
Blood in Urine	Y N

Respiratory

Wheezing	Y N
Frequent Cough	Y N
Shortness of breath	Y N

Hematologic/Lymphatic

Swollen glands	Y N
Blood clotting problems	Y N
Bruising tendency	Y N

Psychologic

Depression	Y N
Anxiety	Y N

Physician Signature: _____

Date: _____



Department of Urology New Patient Intake Form—Male



**Ambulatory Care
Consent and Notice of Privacy Practices
Acknowledgement Form**

Patient Name: _____ Date of Birth: _____

MRN: _____ Enc#: _____

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff. I have been provided a copy of the SBOHCA Joint Notice of Privacy Practices (Notice) and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.

I acknowledge the receipt of the Ambulatory Care Patient Guide on, or prior to this visit.

Signature of Patient or Patient Representative

Print Name of Patient or Personal Representative

Relationship, if signed by person other than Patient

Date _____ Time _____

Signature of Witness

Print Name of Witness

Date _____ Time _____



Department of Urology New Patient Intake Form—Male



**Ambulatory Care
Authorization to Discuss PHI with a Designee**

Patient's Name: _____ Date of Birth: _____
(Please Print Clearly) (Please Print Clearly)

By signing below I hereby give permission to _____
(Name of Physician, Physician Practice or Service Practice)

to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this does not include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Signature of Patient _____

Date _____ Time _____

For Office Use Only

Patient's MRN _____

Date received: _____