

TODAY'S DATE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_  
 PHYSICIAN'S TELEPHONE: \_\_\_\_\_

NAME OF PATIENT:	DATE OF BIRTH:	AGE:
STREET ADDRESS:	SOCIAL SECURITY NUMBER:	
CITY:	MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED	
STATE:            ZIP CODE:	SEX: MALE FEMALE	
HOME TELEPHONE:	CELLULAR TELEPHONE:	

EMPLOYMENT STATUS: (PLEASE CIRCLE)	STUDENT STATUS: (PLEASE CIRCLE)
FULL-TIME, PART-TIME, RETIRED, NOT EMPLOYED	FULL-TIME, PART-TIME, NOT ENROLLED

**INFORMATION REGARDING YOUR EMPLOYMENT**

BUSINESS NAME:	BUSINESS TELEPHONE:
STREET ADDRESS:	JOB TITLE/OCCUPATION:
CITY	
STATE:            ZIP CODE:	

**INFORMATION REGARDING SPOUSE OR LEGAL GUARDIAN OF PATIENT**

NAME:	DATE OF BIRTH:	EMPLOYER:
STREET ADDRESS:	BUSINESS ADDRESS:	
CITY:	BUSINESS TELEPHONE:	
STATE:            ZIP CODE:	JOB TITLE/OCCUPATION:	

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

NAME OF SUBSCRIBER:	NAME OF SUBSCRIBER:
SUBSCRIBER'S ID NUMBER:	SUBSCRIBER'S ID NUMBER:
GROUP NUMBER:	GROUP NUMBER:
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
THIS PERSON'S TELEPHONE NUMBER:	THIS PERSON'S TELEPHONE NUMBER:
SUBSCRIBER'S EMPLOYER:	SUBSCRIBER'S EMPLOYER:
EMPLOYER'S STREET ADDRESS:	EMPLOYER'S STREET ADDRESS:
EMPLOYER'S CITY, STATE & ZIP:	EMPLOYER'S CITY, STATE & ZIP:
EMPLOYER'S TELEPHONE NUMBER:	EMPLOYER'S TELEPHONE NUMBER:

INSURANCE COMPANY:	INSURANCE COMPANY:
STREET ADDRESS:	STREET ADDRESS:
CITY	CITY
STATE:            ZIP CODE:	STATE:            ZIP CODE:

**EMERGENCY CONTACT INFORMATION**

NAME:	RELATIONSHIP TO PATIENT:
HOME TELEPHONE:	WORK TELEPHONE:

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the provider or insurance company or companies to release any information required to process my medical claims. I also authorize my insurance benefits to be paid directly to William M. Dean, M.D. I understand that I am ultimately responsible for all charges associated with medical services.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

**CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE**

**Important Note:** Answer all questions even if you feel they may not apply to your current condition.

**SECTION 1 – TELL US ABOUT YOURSELF**

<b>SINGLE, MARRIED, DIVORCED, WIDOWED</b>	<b>NUMBER OF CHILDREN?</b>	<b>GRANDCHILDREN?</b>
<b>RACE/ETHNICITY: (CIRCLE) CAUCASIAN, AFRICAN-AMERICAN, ASIAN, HISPANIC, NATIVE AMERICAN, OR OTHER:</b>		
<b>OCCUPATION: (CIRCLE ONE) FULL-TIME, PART-TIME, UNEMPLOYED, RETIRED, DISABLED, STUDENT</b>		
<b>HOBBIES:</b>		
<b>EXERCISE: (TYPE AND FREQUENCY)</b>		

**SECTION 2 – MEDICATIONS AND ALLERGIES**

<b>CURRENT MEDICATIONS</b> (include over-the-counter medications, nutritional supplements, etc.)
<ul style="list-style-type: none"> <li>• _____ • _____ • _____ • _____</li> <li>• _____ • _____ • _____ • _____</li> </ul>
<b>ALLERGIES TO MEDICATIONS:</b> (describe your allergic reaction for each allergy listed)
<ul style="list-style-type: none"> <li>• _____ • Reaction: _____</li> <li>• _____ • Reaction: _____</li> </ul>

**SECTION 3 – PAST MEDICAL HISTORY AND/OR HOSPITALIZATIONS**

YES	NO	Have you ever been hospitalized or had surgery?
		<p align="center">If "Yes", list approximate dates, reason for hospitalization(s) and type of surgery.</p> <ul style="list-style-type: none"> <li>• _____ • _____</li> <li>• _____ • _____</li> <li>• _____ • _____</li> <li>• _____ • _____</li> </ul>

**SECTION 4- STONE DISEASE**

Yes	No	Question
		1. Have you ever had a urinary stone?
		If "yes", what type of stone did you have?
		When did you pass the stones?
		2. Do you consume large amounts of dairy products?
		3. Do you use large amounts of antacids?
		4. Do you have a family history of kidney stones?
		5. Have you or a family member been diagnosed with gout?

**SECTION 5 – GENERAL URINARY HISTORY**

Yes	No	Question
		1. Do you have pain with a full bladder?
		2. Do you have pain with intercourse?
		3. Do you have burning with urination?
		4. Have you ever had an x-ray of your kidney(s)?
		If so, did you have an allergic reaction to the dye that was used?
		5. Have you ever had an examination of your bladder?
		6. Have you ever been dilated with a metal instrument?
		7. Have you ever seen blood in your urine?
		8. Have you ever been told that you have blood in your urine?
		9. Have you ever seen blood spotting in your underwear?
		10. Have you ever had a bladder infection?
		If so, was it associated with a fever of 102° or higher?
		If so, how frequently?                      When was the last infection?

### SECTION 6 – GENERAL HEALTH QUESTIONS

Yes	No	Question
		1. Do you smoke?
		If "yes", how many packs per day?
		2. Do you drink alcohol?
		If "yes", how often?
		How much?
		3. Do you use any recreational substances or drugs other than those prescribed by a physician?
		If "yes", what do you use?
		How often?

Yes	No	Question
		4. Do you follow any type of restricted diet? <b>Circle</b> the diet you are presently following, if it is listed here. Otherwise, skip to Question #5. <ul style="list-style-type: none"> <li>• low salt</li> <li>• high fiber</li> <li>• diabetic</li> <li>• vegetarian</li> <li>• low carbohydrate</li> <li>• low fiber</li> <li>• renal</li> <li>• weight reduction</li> </ul>
		5. Tell us about your diet, if it is other than one listed above.
		6. How tall are you? _____ feet _____ inches
		7. How much do you weigh? _____ pounds
		8. Have you ever had a skin test for TB (tuberculosis)?
		9. Have you ever been treated for TB (tuberculosis)?
		10. Have you ever had prolonged bleeding during surgery?
		11. Have you ever had an adverse reaction to a blood transfusion?
		12. Have you ever had any serious injuries such as broken bones or other trauma?

### SECTION 7 – FAMILY HISTORY

Yes	No	Question
		1. Do you or a family member have: (circle all that apply and list relationship, e.g. father, sister, aunt, et cetera)
		<ul style="list-style-type: none"> <li>• high blood pressure? If "Yes", who? _____</li> <li>• diabetes? If "Yes", who? _____</li> <li>• acid reflux or GERD? If "Yes", who? _____</li> <li>• cancer? If "Yes", who? _____</li> <li>• prostate cancer? If "Yes", who? _____</li> </ul>

### SECTION 8 – PAST MEDICAL HISTORY

Yes	No	Question
		1. Have you ever had a heart attack or chest pain that you thought might be a heart attack?
		2. Have you ever fainted or had any other type of blackout spells?
		3. Have you ever had weakness on one side of your body?
		4. What type of contraception do you use, if any?

**SECTION 9 – MALE UROLOGICAL HISTORY**

Yes	No	QUESTION												
		1. Have you ever had a sexually transmitted disease (STD) or a venereal disease? Examples include: Please <u>circle</u> all that apply. <ul style="list-style-type: none"> <li>• genital herpes</li> <li>• syphilis</li> <li>• gonorrhea</li> <li>• HIV</li> <li>• human papilloma virus (HPV) chlamydia or pelvic Inflammatory Disease (PID)</li> <li>• venereal warts (known as condyloma or condylomata)</li> <li>• hepatitis B or D</li> </ul>												
		What STD were you infected with? <span style="float: right;">Approximate date of initial infection?</span>												
		If you have been infected more than once, please list each type of infection and how many times you were infected or had an outbreak and the approximate date(s) of each occurrence.  <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>Type of Infection</u>__</th> <th style="text-align: left;"><u>Date of Diagnosis</u>__</th> </tr> </thead> <tbody> <tr> <td>• _____</td> <td>_____</td> </tr> <tr> <td>• _____</td> <td>_____</td> </tr> <tr> <td>• _____</td> <td>_____</td> </tr> <tr> <td>• _____</td> <td>_____</td> </tr> <tr> <td>• _____</td> <td>_____</td> </tr> </tbody> </table>	<u>Type of Infection</u> __	<u>Date of Diagnosis</u> __	• _____	_____	• _____	_____	• _____	_____	• _____	_____	• _____	_____
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• _____	_____													
• _____	_____													
• _____	_____													
• _____	_____													
• _____	_____													
		2. Do you wake up in the morning with an erection?												
		3. Have you ever noticed blood in your ejaculate or semen?												
		4. Do you have pain with ejaculation?												
		5. Have you ever been treated for prostatitis?												
		If "Yes", how many times?												
		When were you treated for it?												
		When was your most recent treatment for prostatitis?												

PATIENT'S NAME: \_\_\_\_\_  
 TODAY'S DATE \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_

### INTERNATIONAL PROSTATE SYMPTOM SCORE (IPSS)

Answer on a Scale of 0 – 5 with "0" being "Not at all" and "5" being "Almost Always."	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
<b>Incomplete Emptying</b> Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
<b>Frequency</b> Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
<b>Intermittency</b> Over the past month, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5	
<b>Urgency</b> Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
<b>Weak Stream</b> Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
<b>Straining</b> Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
<b>Nocturia</b> Over the past month, 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	1 time 1	2 times 2	3 times 3	4 times 4	5 times or more 5	
<b>TOTAL IPSS SCORE</b> (Add the points from YOUR SCORE. Write the TOTAL in the box at the end of this row.)							<u>TOTAL</u>

### QUALITY OF LIFE INDEX (QOL INDEX)

Quality of Life Due to Urinary Symptoms	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

CONFIDENTIAL SEXUAL HEALTH INFORMATION QUESTIONNAIRE

PATIENT'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_  
HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**How do you rate your confidence that you could get and keep an erection?**

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

**When you have had erections with sexual stimulation, how often were your erections hard enough for penetration?**

1. Not sexually active
2. Almost never
3. A few times
4. Sometimes
5. Most times
6. Almost always

**During sexual intercourse, how often were you able to maintain your erection?**

1. Not sexually active
2. Almost never
3. A few times
4. Sometimes
5. Most times
6. Almost always

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

1. Not sexually active
2. Almost never
3. A few times
4. Sometimes
5. Most times
6. Almost always

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

1. Not sexually active
2. Almost never
3. A few times
4. Sometimes
5. Most times
6. Almost always