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
   ☐ Side effects
   ☐ Expense
   ☐ Interaction with other medications
   ☐ 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**

<table>
<thead>
<tr>
<th>(Bubble ONE number on each line)</th>
<th>Not at All</th>
<th>Less Than 1 Time in 5</th>
<th>Less Than Half the Time</th>
<th>About Half the Time</th>
<th>More Than Half the Time</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCOMPLETE EMPTYING</strong>&lt;br&gt;Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?</td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
<tr>
<td><strong>FREQUENCY</strong>&lt;br&gt;During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?</td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
<tr>
<td><strong>INTERMITTENCY</strong>&lt;br&gt;During the past month or so, how often have you found you stopped and started again several times when you urinated?</td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
<tr>
<td><strong>URGENCY</strong>&lt;br&gt;During the past month or so, how difficult have you found it to postpone urination?</td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
<tr>
<td><strong>WEAK STREAM</strong>&lt;br&gt;During the past month or so, how often have you had a weak urinary stream?</td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
<tr>
<td><strong>STRAINING</strong>&lt;br&gt;Over the past month, or so have you had to push or strain to begin urination?</td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>None</th>
<th>1 Time</th>
<th>2 Times</th>
<th>3 Times</th>
<th>4 Times</th>
<th>5 or more Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
</tbody>
</table>

**NOCTURIA**<br>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?<br>o 0 o 1 o 2 o 3 o 4 o 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)

<table>
<thead>
<tr>
<th>Quality of Life</th>
<th>Delighted</th>
<th>Pleased</th>
<th>Mostly Satisfied</th>
<th>Mixed</th>
<th>Mostly Dissatisfied</th>
<th>Unhappy</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you were to spend the rest of your life with urinary condition the way it is now, how would you feel about that?</td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
<td>o 6</td>
</tr>
</tbody>
</table>
# Erectile Dysfunction

(BUBBLE in ONE number on each line)

<table>
<thead>
<tr>
<th>How often were you able to get an erection during sexual activity?</th>
<th>No sexual activity</th>
<th>Almost never or never</th>
<th>A few times (much less than half the time)</th>
<th>Sometimes (about half the time)</th>
<th>Most times (much more than half the time)</th>
<th>Almost always or Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When you had erections with sexual stimulation, how often were your erections hard enough for penetration?</th>
<th>No sexual activity</th>
<th>Almost never or never</th>
<th>A few times (much less than half the time)</th>
<th>Sometimes (about half the time)</th>
<th>Most times (much more than half the time)</th>
<th>Almost always or Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When you attempted sexual intercourse, how often were you able to penetrate (enter) your partner?</th>
<th>Did not attempt intercourse</th>
<th>Almost never or never</th>
<th>A few times (much less than half the time)</th>
<th>Sometimes (about half the time)</th>
<th>Most times (much more than half the time)</th>
<th>Almost always or Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During sexual intercourse, were you able to maintain your erection after you had penetrated (entered) your partner?</th>
<th>Did not attempt intercourse</th>
<th>Almost never or never</th>
<th>A few times (much less than half the time)</th>
<th>Sometimes (about half the time)</th>
<th>Most times (much more than half the time)</th>
<th>Almost always or Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During intercourse, how difficult was it to maintain your erection to completion of intercourse?</th>
<th>Did not attempt intercourse</th>
<th>Extremely difficult</th>
<th>Very difficult</th>
<th>Difficult</th>
<th>Slightly difficult</th>
<th>Not difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o 0</td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do you rate your confidence that you could get and keep an erection?</th>
<th>Very Low</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o 1</td>
<td>o 2</td>
<td>o 3</td>
<td>o 4</td>
<td>o 5</td>
</tr>
</tbody>
</table>

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

3
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
- 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

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: Living Deceased-Cause:
- Brother: Living Deceased-Cause:

Surgical History
1. Have you ever had surgery? Yes No
2. Please list approximate dates and reasons for any surgery (including childbirth):
   - Date
   - Surgeries

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

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Reason for taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tylenol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advil/Motrin/Ibuprofen</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Review of symptoms

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

### Constitutional Symptoms
- Fever: [ ]
- Chills: [ ]
- Sweats: [ ]
- Weakness: [ ]
- Fatigue: [ ]

### Eyes
- Blurred Vision: [ ]
- Double Vision: [ ]
- Pain: [ ]

### Immunologic
- Recurrent Fevers: [ ]
- Recurrent Infections: [ ]
- Malaise: [ ]

### Neurological
- Confusion: [ ]
- Numbness/Tingling: [ ]
- Dizzy Spells: [ ]
- Headache: [ ]

### Endocrine
- Excessive Thirst: [ ]
- Too hot/Cold: [ ]
- Excessive Hunger: [ ]

### Gastrointestinal
- Abdominal Pain: [ ]
- Nausea/Vomiting: [ ]
- Indigestion/heartburn: [ ]
- Diarrhea: [ ]

### Cardiovascular
- Chest Pain: [ ]
- Palpitations: [ ]
- Ankle Swelling: [ ]

### Integumentary
- Skin Rash: [ ]
- Boils: [ ]
- Persistent itch: [ ]
- Burns: [ ]
- Skin Lesion: [ ]

### Musculoskeletal
- Joint pain: [ ]
- Neck Pain: [ ]
- Back Pain: [ ]

### Ears/Nose/Throat/Mouth
- Ear Infection: [ ]
- Sore Throat: [ ]
- Sinus Problems: [ ]

### Genitourinary
- Urine Retention: [ ]
- Painful Urination: [ ]
- Urinary Frequency: [ ]
- Blood in Urine: [ ]

### Respiratory
- Wheezing: [ ]
- Frequent Cough: [ ]
- Shortness of breath: [ ]

### Hematologic/Lymphatic
- Swollen glands: [ ]
- Blood clotting problems: [ ]
- Bruising tendency: [ ]

### Psychologic
- Depression: [ ]
- Anxiety: [ ]

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Physician Signature: ___________________________
Date: ____________________
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 ___________________________

Name of Individual ___________________________ Relationship to patient ___________________________

_______________________________
Signature of Patient

_______________________________
Date Time

For Office Use Only

Patient’s MRN ___________________________

Date received: ___________________________