Stony Brook Medicine

Department of Urology New Patient Intake Form-Male

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

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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)

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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?	o **0**	o **1**	o **2**	o **3**	o **4**	o **5**
FREQUENCY During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	o **0**	o **1**	o **2**	o **3**	o **4**	o **5**
INTERMITTENCY During the past month or so, how often have you found you stopped and started again several times when you urinated?	o **0**	o **1**	o **2**	o **3**	o **4**	o **5**
URGENCY During the past month or so, how difficult have you found it to postpone urination?	o **0**	o **1**	o **2**	o **3**	o **4**	o **5**
WEAK STREAM During the past month or so, how often have you had a weak urinary stream?	o **0**	o **1**	o **2**	o **3**	o **4**	o **5**
STRAINING Over the past month, or so have you had to push or strain to begin urination?	o **0**	o **1**	o **2**	o **3**	o **4**	o **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?	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)

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?	o **0**	o **1**	o **2**	o **3**	o **4**	o **5**	o **6**

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Erectile Dysfunction

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

o None o Pills (e.g. Viagra) o Muse o Injections oVacuum device oPenile Prosthesis

Past Medical & Social History

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Please answer the following questions

Medical History

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

☐ Parkinson's ☐ Multiple Sclerosis
☐ Heart Disease ☐ Heart Attack
☐ High Blood Pressure ☐ Lung (COPD, Asthma)
☐ High Cholesterol/triglyceride ☐ Sexually transmitted disease
☐ Stroke/TIA ☐ Diabetes
☐ Thyroid ☐ Seizures/Epilepsy
☐ 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 _____
_____

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 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: _____ _____

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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

Physician Signature: _____

Date: _____

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

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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

SPANISH VER.:AD2C037ST

AD2C034 (2/13)

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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: _____

This form is for office use only. Place in the correspondence section of the medical record. Not for release or disclosure.