

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

Names of <i>ALL</i> Physicians			
Name	Phone	City	Specialty

FAMILY HISTORY			
RELATION	AGE(S)	STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			
Spouse			
Children			
Are you of Ashkenazi Jewish descent?		YES <input type="checkbox"/>	NO <input type="checkbox"/>

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.	
Disease	Family member

REVIEW OF SYSTEMS					
Have you experienced any of these problems during the past month?					
	YES	NO		YES	NO
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Mood changes or Depression	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Skin rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance or coordination	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea or constipation	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Vision trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contacts or glasses?	<input type="checkbox"/>	<input type="checkbox"/>	Foul-smelling urine	<input type="checkbox"/>	<input type="checkbox"/>
Arm or leg weakness	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>			
Hoarseness or change in voice	<input type="checkbox"/>	<input type="checkbox"/>			
Sores in mouth or lip	<input type="checkbox"/>	<input type="checkbox"/>			
Cough	<input type="checkbox"/>	<input type="checkbox"/>			
Coughed up or spit up blood	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

ERECTILE DYSFUNCTION		YES	NO
1. Do you have problems with erections?		<input type="checkbox"/>	<input type="checkbox"/>
2. If YES,			
a)	Do you awaken in the morning or night with a good erection?	<input type="checkbox"/>	<input type="checkbox"/>
b)	Does your sexual partner give you plenty of stimulation (oral/manual) to help you achieve or maintain an erection?	<input type="checkbox"/>	<input type="checkbox"/>
c)	Do you have trouble obtaining an erection?	<input type="checkbox"/>	<input type="checkbox"/>
d)	Do you have trouble maintaining an erection?	<input type="checkbox"/>	<input type="checkbox"/>
e)	Do you have curvature with erections?	<input type="checkbox"/>	<input type="checkbox"/>
f)	Do you have painful erections?	<input type="checkbox"/>	<input type="checkbox"/>
g)	Is sex an important part of your life?	<input type="checkbox"/>	<input type="checkbox"/>
3. On a scale of 1 to 10, rate the quality of your erections now (10 being when you were 18 years old) _____			
4. When attempting intercourse, how many times out of every 10 tries will you successfully penetrate and achieve orgasm? _____			

SOCIAL HISTORY		
(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
<input type="checkbox"/>	ALCOHOL	Year: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Occasional/Social <input type="checkbox"/> Drinks/Day: _____
<input type="checkbox"/>	SMOKING STATUS	<input type="checkbox"/> Current/Every Day <input type="checkbox"/> Current/Some Days <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoker <input type="checkbox"/> Unknown
<input type="checkbox"/>	TOBACCO	Year: _____ Pack(s) A Day: _____ Quit: <input type="checkbox"/> NO <input type="checkbox"/> YES <i>If YES, Date Quit:</i> _____
<input type="checkbox"/>	STREET DRUGS/OTHER	Year: _____ Type: _____ Do you use needles? <input type="checkbox"/> NO <input type="checkbox"/> YES
<input type="checkbox"/>	HIV positive or AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

Prostate Health for Men Over 40

Are you bothered by urinary symptoms? Take this test- you may have BPH. BPH (benign prostatic hyperplasia is a non-cancerous enlargement of the prostate that occurs in many men over the age of 40.

Use this form to assess your symptoms, and share your results with your doctor.

To use this symptom scorecard: *Check one number in each line then add all checked numbers to get the total score. The total runs from 0 to 35 points with higher scores indicating more severe symptoms. Scores less than 7 are considered mild and generally do not warrant treatment.*

AUA and BPH SYMPTOM SCORE						
	Not at all	Less than 1 in 5 time(s)	Less than half the time	About half the time	More than half the time	Almost always
INCOMPLETE EMPTYING Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FREQUENCY Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
INTERMITTENCY Over the past month, how often have you found you stopped and started again several times when you urinated?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
URGE TO URINATE Over the past month, how often have you found it difficult to postpone urination?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
WEAK STREAM Over the past month, how often have you had a weak urinary stream?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
STRAINING Over the past month, how often have you had to push or strain to begin urination?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
URINATING AT NIGHT 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 <input type="checkbox"/> 0	1 TIME <input type="checkbox"/> 1	2 TIMES <input type="checkbox"/> 2	3 TIMES <input type="checkbox"/> 3	4 TIMES <input type="checkbox"/> 4	5 TIMES <input type="checkbox"/> 5
SYMPTOM SCORE: 1-7 Mild, 8-19 Moderate, 20-35 Severe				Total: _____		

BOTHER SCORE DUE TO URINARY SYMPTOMS Rate the bothersomeness of your symptoms by checking the number below that best describes your feelings							
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
BOTHERSOME OR URINARY SYMPTOMS How would you feel if you had to live with your urinary condition the way it was now, no better, no worse, for the rest of your life?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

CURRENT MEDICATION LIST			
DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES

None Penicillin Codeine Sulfa Cipro Macrobid

Other (List All):

MEDICATION	SPECIFIC TYPE OF REACTION

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to Pacific Urology to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

*** SIGNATURE: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

Name & Address (Location) of Preferred OUTSIDE Pharmacy: Is this is a MAIL ORDER PHARMACY? Yes No

Please list a local pharmacy for urgent prescriptions if primary is a mail order.

Name & Address/Phone of LOCAL pharmacy: