TMH PHYSICIAN PARTNERS

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UROLOGY SPECIALISTS
NEW PATIENT MEDICAL HISTORY FORM (MALE)

Patient Name: ______________________________ **Today's Date:** _______________________

Date of Birth: ______________________ **Age:** __________ **Height:** _________ **Weight:** _______

Reason for visit?____

Referring physician: ________________________ **Primary Care Physician:** ________________________

Please check any of the following health problems you have had or have now:

[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Stroke (or Mini-stroke)
[ ] Diabetes
[ ] Heart Disease
[ ] Kidney Stones
[ ] Kidney Infection
[ ] Shortness of Breath
[ ] Heart Murmur
[ ] Cancer
[ ] HIV
[ ] Blood clotting problems

List Operations or Procedures and when?

Year	Surgery	Year	Surgery

Family History: Please check the following health problems that have affected your family and identify their relationship to you, ie: mother, father, grandparent, sibling.

[ ] Prostate Cancer ____________ [ ] Bladder Cancer _____________ [ ] Kidney Stones _____________

Urinary Complaints:

Do your experience urinary frequency during the day? [ ] No [ ]Yes If yes, how often? ____________

Do you wake up at night to urinate? [ ] No [ ]Yes If yes, how often? ____________

Have you ever seen blood in your urine? [ ] No [ ]Yes

Have you ever had a urinary tract infection? [ ] No [ ]Yes If yes, how often? ____________

Do you have to push or strain to begin urination? [ ] No [ ]Yes

Does your urinary stream stop and start? [ ] No [ ]Yes

Do you experience incomplete bladder emptying? [ ] No [ ]Yes

Do you have burning or discomfort with urination? [ ] No [ ]Yes

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Do you ever have the urge to rush to urinate? [ ] No [ ]Yes If yes when? ______________

Do you ever lose control or leak urine suddenly? [ ] No [ ]Yes

Do you ever leak urine when you cough, sneeze, or exercise? [ ] No [ ]Yes

Do you wear pads to collect urinary leakage? [ ] No [ ]Yes If yes, how many? __________

Are you bothered by the way you urinate? [ ] No [ ]Yes

Do you have pain associated with your bladder or pelvic area (lower abdomen, penis, urethra, testicles, or scrotum)? [ ] No [ ]Yes If yes, since when? __________

Are you sexually active? [ ]No [ ]Yes

Any history of sexually transmitted disease (STD)? [ ]No [ ] Yes If yes, which STD? ____________

Do you have difficulty:
- Initiating an erection? [ ] No [ ]Yes
- Maintaining an erection? [ ] No [ ]Yes
- Reaching ejaculation? [ ] No [ ]Yes
- Problem with libido or sex drive? [ ] No [ ]Yes

Rate the quality of your erection 1 to 10 (10 is the strongest): 1 2 3 4 5 6 7 8 9 10 (circle one)

Do you drink coffee? [ ] No [ ] Yes; if yes, how many cups per day? __________

Do you use tobacco products? [ ]No [ ]Yes; if yes, packs /day: ________Year Quit: __________

Do you drink alcohol? [ ]No [ ]Yes; if Yes, drinks per day _____ Per week: _______

Do you use recreational drugs? [ ]No [ ]Yes; if yes, describe: ______________________________________

Have you lost interest in doing things that use to give you pleasure?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you been feeling down, depressed or hopeless in the past 2 weeks?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you experienced 10 lbs weight loss or weight gain in the past 3 months? [ ] No [ ] Yes

Do you have problems with mobility (use a wheelchair, cane or walker)? [ ]No [ ] Yes; if yes, please describe the problem and/or the device used.____

Have you had a fall in the past year? [ ] No [ ] Yes

Do you feel unsteady? [ ] No [ ] Yes

Are you in a relationship where you are being threatened or hurt? [ ] No [ ] Yes

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Patient Name:____ **Date of Birth** :________________________

List Drug, Food, or Substance Allergies & Reactions:

____

____

____

Preferred Pharmacy:____________________________ **Pharmacy Location:**_________________________________

Complete your medication list to the best of your ability:

Date	Drug	Dose	Frequency	Indication

***Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician.

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INTERNATIONAL PROSTATE SYMPTOM SCORE (I-PSS)

Patient's Name: ______________________________ Date of Birth: ______________ Today's Date: ________________

Please circle the number which reflects the best answer to each question.

		Not at all	Maybe once every 5 times	Less than half the fime	About half the time	More than half the time	Almost always	
1. Incomplete Emptying	Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
2. Frequency	Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency	Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency	Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream	Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining	Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
		None	1 time	2 times	3 times	4 times	5 or more times	
7. Nocturia	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?	0	1	2	3	4	5	
							Total I-PSS Score	

	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

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Patient's Name: ____ Date of Birth: _________________ Date Completed:___________________

Sexual Health Inventory for Men (SHIM)

Instructions:

Each question has 5 possible responses. Circle the number that best describes your own situation.
Select only 1 answer for each question.

Over the past 6 months:

1. How do you rate your confidence that you could keep an erection?

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

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

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

1	2	3	4	5
Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult

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

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

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Scoring Instructions:

Add the numbers corresponding to the answeres for questions 1 through 5. If the patient's score is 21 or less, erectile dysfunction (ED) should be addressed. The SHIM score characterizes the severity of the patient's ED in the following manner:

22-25 No ED
17-21 Mild ED
12-16 Mild-to-moderate ED
8-11 Moderate ED
5-7 Severe ED

Score: ______________________