Advanced Urological Care P.C.
Male Urinary and Sexual Dysfunction

Patient History Form

J. Francois Eid, M.D.

Note: Confidential

Date: _____

Name: _____

Address: _____

_____

Age: _____ Date of Birth: _____

Height: _____ Weight: _____

We would like to send a letter to update your referring physician. Yes No

Referring Physician: _____

Telephone Number: _____

Primary Care Physician: _____

Telephone Number: _____

Note: If the telephone number is not provided, no letter will be sent out.

Chief Complaint:

What is the main reason for your office visit today (please describe in detail)?

_____

_____

History of Present Sexual Function

1. Circle the current level of your interest in sexual relations

High About Right Less than it has been before

2. Erectile Function

A. When did your sexual problem start? _____
B. Was the onset sudden or gradual? _____
C. Before the problem, how often did you have intercourse? _____

D. How often do you attempt intercourse now? _____
E. What percent of the time are you able to penetrate? _____

F. When was the last time you were able to penetrate? _____

G. Has the shape of your erect penis changed?	Yes	No
H. Are you presently able to have partial erection?	Yes	No
I. Do you ever lose your erection during intercourse?	Yes	No
J. Do you ever ejaculate with a soft penis?	Yes	No

K. Circle the number that best describes the quality of your erections.

1. Limp penis.
2. Full penis, no hardness, no penetration.
3. Occasional penetration, but no maintaining ability.
4. Sufficient for penetration, but no maintaining ability.
5. Able to penetrate easily and maintain to orgasm.

L. Using the same scale above, circle the number which best describes your erection with masturbation.

1 2 3 4 5 N/A

M. Do you have erections at night? _____ On awakening? _____

N. How do these erections compare with your sexually induced erections?

Same Better Worse

O. Does your ability to have an erection vary with different partners?

Yes No N/A

Sexual Health Inventory for Men

Patient Instructions

This questionnaire is designed to help us quantify and treat your erectile dysfunction. You will be asked to complete this questionnaire in the future to measure the success of the treatment.

Over the past six months:

1. How do you rate your **confidence** that you can get and keep and erection?	0 1 2 3 4 5
2. When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)?	0 1 2 3 4 5
3. During sexual intercourse, **how often** were you able to maintain your erection after you had entered your partner?	0 1 2 3 4 5
4. During sexual intercourse, **rate your ability** to maintain your erection to completion of intercourse.	0 1 2 3 4 5
5. When you attempted sexual intercourse, **how often** was it satisfactory for you?	0 1 2 3 4 5
Add the numbers corresponding to the questions 1-5.	**Total:**

Your score: _____

If you scored between **1-7**, you may have severe erectile dysfunction.

If you scored between **8-11**, you may have moderate erectile dysfunction.

If you scored between **12-16**, you may have mild to moderate erectile dysfunction.

If you scored between **17-21**, you may have mild erectile dysfunction.

If you scored between **22-25**, you have normal erectile function.

3. Climax or Orgasm

A. Are you able to have a climax or orgasm? Yes No

B. Does semen (fluid) come out of your penis when you have orgasm? Yes No

C. If yes, is the amount the same when you have/had erections? Yes No

D. Have you noticed any change in the sensitivity of your penis? Yes No

4. Sexual History

A. Sexual Orientation: Heterosexual Bisexual Homosexual

B. Are you: Married Single Widowed Divorced

C. Do you have a regular/steady partner? Yes No

D. If you are in a relationship:

1. How many years have you been together? _____

2. Describe the quality of your relationship: _____

_____

3. Describe the quality of your sexual relationship: _____

_____

4. Does your partner contribute to your sexual dysfunction? Yes No

5. Is your partner interested in having your sexual problem treated? Yes No

5. Past Evaluation of Sexual Function

A. Did you ever see a doctor(s) for this problem before? Yes No

If yes, were there any diagnostic tests performed? Yes No

If yes, which ones?

1. Hormone Blood Level Yes No
2. Penile Injection Test Yes No
3. Sleep Test (Neva) Yes No
4. Penile Ultrasound (Duplex) Yes No
5. Other _____

6. Past Treatment of Sexual Dysfunction

A. Were you ever treated with pills? Yes No

If yes, which ones?

1. Viagra 25 50 100 mg Yes No

Frequency _____ Result _____

Side effects _____

2. Cialis 5 10 20 mg Yes No

Frequency _____ Result _____

Side effects _____

3. Levitra 5 10 20 mg Yes No

Frequency _____ Result _____

Side effects _____

B. Were you treated with any of the following:

1. Urethral suppositories (Muse)? Yes No
Frequency _____ Result _____
Side effects _____

2. Penile Injections? Yes No
Frequency _____ Result _____
Side effects _____

3. External vacuum device? Yes No
Frequency _____ Result _____
Side effects _____

Past Medical and Social History

1. Do you have any medical illnesses or conditions? No Yes Onset/Duration

Circle any of the following that apply:
1. High blood pressure Date: _____
2. High cholesterol levels Date: _____
3. Heart disease Date: _____
4. Diabetes Date: _____
5. Prostate cancer Date: _____
6. Sleep Apnea
7. Sickle Cell Trait or Disease

List other illness or medical condition:

_____

2. List all <u>serious</u> illnesses in your immediate family.

_____

3. List any previous treatments and surgeries (operations) and when they occurred.

Hernia repair: __Right __ Left __ Bilateral __ Mesh __ Without Mesh Date: _____

Cardiac Catheterization/Stent: _____ Date: _____

Pacemaker Type: ___ St. Jude Date: _____(Please provide us with your device ID)
___ Medtronic Date: _____(Please provide us with your device ID)

Prostate Cancer Surgery: _____ Date: _____

Robotic _____ Laparoscopic _____ Open _____

Kidney Transplant: __ Right __ Left Date: _____

Penile Implant: _____ Date: _____

Rigid ___ Two Piece ___ Multi Component Inflatable ____
AMS ___ Coloplast (Mentor) ____

Radiation Therapy: External Beam _____ Seeds _____ Date: _____

Chemotherapy: _____ Date: _____

Bladder/Colon: _____ Date: _____

4. Drug Allergies: Yes No

Please list: _____

5. Medications: Yes No

Please list all drugs, medications, eye drops, etc. including dose and frequency

_____

_____

Do you take any blood thinners? Yes No

If so, which one? Aspirin ____ Coumadin _____ Plavix _____ Pradaxa _____

Do you take any medications that fall into the category of nitrates? Yes No

Do you carry nitroglycerin with you in case of emergencies? Yes No

Do you use a skin patch for the delivery of medications? Yes No

6. Alcohol Intake:

Do you drink alcohol (beer, wine, liquor, etc.)? Yes No

If yes: Type _____ Amount _____

7. Tobacco Use:

Do you or did you ever smoke? Yes No

If yes: How many pack(s) per day? _____

For how many years? _____

If you stopped, how long ago? _____

8. Psychological History:

Have you ever consulted a psychiatrist, psychologist, or other psychotherapist?

Yes No

If yes, please describe the reason: _____

_____

_____

Were you diagnosed with any of the following:

Depression? Yes No

Obsessive-compulsive disorder? Yes No

Bipolar disorder? Yes No

Psychosis/Neurosis? Yes No

Physician's Notes:

BENIGN PROSTATE ENLARGEMENT

Last digital rectal examination: _____ Last PSA:_____

Urinary Symptoms	**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**
1. Over the past month, how often have you had the sensation that your bladder was not completely empty after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate again less than two hours after you last finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times while urinating?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urinating?	0	1	2	3	4	5

7. Over the last month, how many times did you typically get up to urinate each night, from the time you until the time you got up in the morning?

None 1 time 2 times 3 times 4 times 5 or more times

TOTAL AUA Symptom Score = Sum of questions 1 -7 _____

Review of Symptoms

Do you now or have you had any problems related to the following symptoms? Circle Yes or No. **Please explain any "Yes" answers in the space provided.**

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Headaches	Yes	No
Weight loss	Yes	No
Other _____	Yes	No

Eyes

Blurred vision	Yes	No
Double vision	Yes	No
Pain	Yes	No
Other _____	Yes	No

Neurological

Tremors	Yes	No
Dizzy spells	Yes	No
Numbness	Yes	No
Other _____	Yes	No

Integumentary

Skin rash	Yes	No
Boils	Yes	No
Persistent itch	Yes	No
Other _____	Yes	No

Musculoskeletal

Joint pain	Yes	No
Neck pain	Yes	No
Back pain	Yes	No
Other _____	Yes	No

Ear/ Nose/ Throat/ Mouth

Ear infection	Yes	No
Sore throat	Yes	No
Sinus problems	Yes	No
Other _____	Yes	No

Genitourinary

Urine retention	Yes	No
Painful urination	Yes	No
Urinary frequency	Yes	No
Other _____	Yes	No

Endocrine

Excessive thirst	Yes	No
Too hot/cold	Yes	No
Tired/sluggish	Yes	No
Other _____	Yes	No

Gastrointestinal

Abdominal pain	Yes	No
Nausea/ vomiting	Yes	No
Indigestion	Yes	No
Other _____	Yes	No

Cardiovascular

Chest pain	Yes	No
Varicose veins	Yes	No
High blood pressure	Yes	No
Other _____	Yes	No

Respiratory

Wheezing	Yes	No
Frequent coughs	Yes	No
Shortness of breath	Yes	No
Other _____	Yes	No

Hematological / Lymphatic

Swollen glands	Yes	No
Blood clot problems	Yes	No
Other _____	Yes	No

Allergic / Immunologic

Hay fever	Yes	No
Drug allergies	Yes	No
Other _____	Yes	No

Psychological

Are you generally satisfied with your life? Yes No

Do you feel seriously depressed? Yes No

Have you considered suicide? Yes No

Other _____

New Patient Questionnaire

Name: _____

Date: _____

Thank you in advance for filling out this quick survey.

How were you referred to Dr. Eid?

_____ Another Doctor
If so, who referred you? _____

_____ Newspaper Advertisement
If so, which newspaper?
_____ Daily News
_____ NY Post
_____ Newsday
_____ AM NY
_____ El Diario
_____ Other

_____ Newspaper Article
If so, which newspaper?
_____ Daily News
_____ NY Post
_____ Newsday
_____ AM NY
_____ El Diario
_____ Other

_____ Internet
If so, which web site?
_____ Advanced Urological Care Web site
_____ Search Engine
_____ Healthology (ABC News)
_____ YouTube
_____ Facebook
_____ Other: _____

_____ Other Publication
If so, which one?
_____ New York Magazine "Best Doctors" Issue
_____ Connelly's Guide
_____ Other: _____

_____ Friend

_____ Self-Referral

_____ Other: _____