**Davis Urology, PLLC**
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Welcome to our practice. As a new or re-established patient, we need to develop and review your medical history database. In preparation for your office visit, we kindly ask that you fill out this questionnaire to the best of your ability. The form may seem lengthy but should expedite your evaluation and treatment as we seek solutions to your particular problem.

**Patient Name:** ______________________ Date of Birth: ______________

Email Address: ______________________

Chief Complaint: ______________________ Primary Care Physician: ______________

**History of Present Illness:**

- Location ______________________
  (Where is the pain/problem?)
- Quality ______________________
  (Example: normal versus abnormal color, activity, etc.)
- Severity ______________________
  (How severe is the pain/problem on a scale of 1-5, 5 being the most severe?)
- Duration ______________________
  (How long have you had this pain/problem? or When did it start?)
- Timing ______________________
  (Does this pain/problem occur at a specific time?)
- Context ______________________
  (Where were you at the onset of this pain/problem?)
- Associated signs/symptoms ______________________
  (What other associated problems have you been having?)
- Modifying factors ______________________
  (What makes the pain/problem worse or better? Or have you had previous episodes?)

**Medical History:**

Patient Medical History:

| | | | Other: |
|---|---|---|---|
| Diabetes | No | Yes | ______________ |
| Cancer | No | Yes | ______________ |
| Stroke | No | Yes | ______________ |
| Heart Trouble | No | Yes | ______________ |
| Arthritis/gout | No | Yes | ______________ |
| Convulsions | No | Yes | ______________ |
| Bleeding Tendency | No | Yes | ______________ |
| Acute infections | No | Yes | ______________ |
| Venereal Disease | No | Yes | ______________ |
| Hereditary Disease | No | Yes | ______________ |

| **Surgical History** | **Date Occurred** |
|---|---|
| ______________________ | ______ |
| ______________________ | ______ |
| ______________________ | ______ |

**Social History:**

| | | | | | |
|---|---|---|---|---|---|
| Marital Status: | Single | Married | Separated | Divorced | Widowed |
| Use of Alcohol | Never | Rarely | Moderate | Daily | |
| Use of Tobacco | Never | Previously, but quit: _____ | | Current packs/day: ______ | |
| Use of Drugs | Never | Type/Frequency: ________________________________________ | | | |

**Family Medical History:**

| | Age | Living or Deceased | | Significant medical problems |
|---|---|---|---|---|
| Father | ________ | L | D | ____________________________________________ |
| Mother | ________ | L | D | ____________________________________________ |
| Siblings | ________ | L | D | ____________________________________________ |
| | ________ | L | D | ____________________________________________ |
| | ________ | L | D | ____________________________________________ |
| Spouse | ________ | L | D | ____________________________________________ |
| Children | ________ | L | D | ____________________________________________ |
| | ________ | L | D | ____________________________________________ |

**Your Current Medications and Dosages:**

This section is not needed if your PCP is a Mercy Physician

| | Currently Taking? | |
|---|---|---|
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |
| ____________________________________________ | Y | N |

## REVIEW OF SYSTEMS

### CONSTITUTIONAL SYMPTOMS
Good general health lately ........................ No Yes
Recent weight change ........................ No Yes
Fever ........................ No Yes
Fatigue ........................ No Yes
Headaches ........................ No Yes

### EYES
Eye disease or injury ........................ No Yes
Wear glasses/contacts ........................ No Yes
Blurred or double vision ........................ No Yes
Glaucoma ... **Wide Angle / Narrow Angle** ............ No Yes

### EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing........................ No Yes
Earaches or drainage ........................ No Yes
Chronic sinus problem or rhinitis ........................ No Yes
Nose bleeds ........................ No Yes
Mouth sores ........................ No Yes
Bleeding gums ........................ No Yes
Bad breath or bad taste ........................ No Yes
Sore throat or voice change ........................ No Yes
Swollen glands in neck ........................ No Yes

### CARDIOVASCULAR
Heart trouble ........................ No Yes
Chest pain or angina pectoris ........................ No Yes
Palpitations ........................ No Yes
Shortness of breath with walking or lying flat ... No Yes
Swelling of feet, ankles or hands ........................ No Yes

### RESPIRATORY
Chronic or frequent coughs ........................ No Yes
Spitting up blood ........................ No Yes
Shortness of breath ........................ No Yes
Asthma or wheezing ........................ No Yes

### GASTROINTESTINAL
Loss of appetite ........................ No Yes
Change in bowel movements ........................ No Yes
Nausea or vomiting ........................ No Yes
Frequent diarrhea ........................ No Yes
Painful bowel movements or constipation ....... No Yes
Rectal bleeding or blood in stool ........................ No Yes
Abdominal pain ........................ No Yes
Peptic ulcer (stomach or duodenal) ........................ No Yes

### GENITOURINARY
Frequent urination ........................ No Yes
Burning or painful urination ........................ No Yes
Blood in urine ........................ No Yes
Change in force of stream when urinating .........No Yes
Incontinence or dribbling ........................ No Yes
Kidney stones ........................ No Yes
Sexual difficulty ........................ No Yes
Male – testicle pain ........................ No Yes
Female – pain with periods ........................ No Yes
Female – irregular periods ........................ No Yes
Female – vaginal discharge ........................ No Yes
Female - # of pregnancies ........................ ________
Female - # of miscarriages ........................ ________
Female – date of last pap smear ........................ ________

### MUSCULOSKELETAL
Joint pain ........................ No Yes
Joint stiffness ........................ No Yes
Weakness of muscles or joints ........................ No Yes
Muscle pain or cramps ........................ No Yes
Back pain ........................ No Yes
Cold extremities ........................ No Yes
Difficulty in walking ........................ No Yes

### INTEGUMENTARY (skin and breast)
Rash or itching ........................ No Yes
Change in skin color ........................ No Yes
Change in hair or nails ........................ No Yes
Varicose veins ........................ No Yes
Breast pain ........................ No Yes
Breast lump ........................ No Yes
Breast discharge ........................ No Yes
Date of last mammogram ........................ ________

### NEUROLOGICAL
Frequent or recurring headaches ........................ No Yes
Light headedness or dizziness ........................ No Yes
Convulsions or seizures ........................ No Yes
Numbness or tingling sensations ........................ No Yes
Tremors ........................ No Yes
Paralysis ........................ No Yes
Stroke ........................ No Yes
Head injury ........................ No Yes

### PSYCHIATRIC
Memory loss or confusion ........................ No Yes
Nervousness ........................ No Yes
Depression ........................ No Yes
Insomnia ........................ No Yes

### ENDOCRINE
Glandular or hormone problem ........................ No Yes
Thyroid disease ........................ No Yes
Diabetes (insulin or non-insulin – circle one)..... No Yes
Excessive thirst or urination ........................ No Yes
Heat or cold intolerance ........................ No Yes
Skin becoming drier ........................ No Yes
Change in hat or glove size ........................ No Yes

### HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts ........................ No Yes
Bleeding or bruising tendency ........................ No Yes
Anemia ........................ No Yes
Phlebitis ........................ No Yes
Past transfusion ........................ No Yes
Enlarged glands ........................ No Yes

### ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
Penicillin ........................ No Yes
Morphine, Demerol or other narcotics ............ No Yes
Novocain or other anesthetics ........................ No Yes
Aspirin or other pain remedies ........................ No Yes
Tetanus antitoxin or other serums ........................ No Yes
Iodine, methiolate or other antiseptic ............ No Yes
Other drugs/medications ________________________
Known food allergies: ________________________
Environmental allergies: ________________________

# SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

**PATIENT NAME:** ______________________________ **TODAY'S DATE:** ___________

## PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

## OVER THE PAST 6 MONTHS:

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. How do you rate your confidence that you could get and keep an erection? | | VERY LOW | LOW | MODERATE | HIGH | VERY HIGH |
| | | 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)? | NO SEXUAL ACTIVITY | 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 |
| | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner? | DID NOT ATTEMPT INTERCOURSE | 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 |
| | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse? | DID NOT ATTEMPT INTERCOURSE | EXTREMELY DIFFICULT | VERY DIFFICULT | DIFFICULT | SLIGHTLY DIFFICULT | NOT DIFFICULT |
| | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. When you attempted sexual intercourse, how often was it satisfactory for you? | DID NOT ATTEMPT INTERCOURSE | 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 |
| | 0 | 1 | 2 | 3 | 4 | 5 |

**Add the numbers corresponding to questions 1-5.** **TOTAL:** __________

**The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:**

**1-7 Severe ED** **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**

UROLIFT®
BPH Relief. In Sight.™

## STAY ON TOP OF YOUR BPH SYMPTOMS

Take the IPSS Survey to measure the severity of your BPH symptoms

## International Prostate Symptom Score (IPSS)

Patient Name: ______________________________ Today's Date: ______________

Daytime Phone Number: ______________________________ Date of Birth: ______________

### Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

| Over the past month | Not at all | Less than one time in five | Less than half the time | About half the time | More than half the time | Almost always |
|---|---|---|---|---|---|---|
| **Incomplete emptying** – How often have you had the sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Frequency** – How often have you had to urinate again less than two hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Intermittency** – How often have you found you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Urgency** – How often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Weak stream** – How often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Straining** – How often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| **Sleeping** – 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 0 | One Time 1 | Two Times 2 | Three Times 3 | Four Times 4 | Five or More Times 5 |
| Add Symptom Scores: | + | + | + | + | + | |

**Total International Prostate Symptom Score =** ______________

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms
Regardless of the score, if your symptoms are bothersome you should notify your doctor.

## Quality of Life (QoL)

| | 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 |
| Have you tried medications to help your symptoms? | | | | | | Yes | No |

Did these medications help your symptoms? (circle)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

*No Relief* — *Complete Relief*

| Would you be interested in learning about a minimally invasive option that could allow you to avoid or discontinue enlarged prostate medications? | Yes | No |
|---|---|---|

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