

PATIENT HEALTH QUESTIONNAIRE: Urology

Patient Name: _____
Last, First, Middle Initial

Sex: M F

Email: _____

Date of Birth: ____________ **Age:** ____ **Social Sec #:** ____-____-____

Type of visit: Consultation requested by another Physician Self-referred Second Opinion

A. PHYSICIAN INFORMATION

Were you referred to USF Health by a physician? Yes No

Primary Care MD: _____

Address: _____

Phone: _____

Fax: _____

Referring Physician: _____

Specialty: _____

Address: _____

Phone: _____

Fax: _____

B. CHIEF COMPLAINT (the main reason for seeking medical attention at USF Health):

C. HISTORY OF PRESENT ILLNESS Briefly describe your symptoms, when they started and treatment you have received.

D. SOCIAL HISTORY

Smoking:

Do you smoke? Yes No If yes, # packs per day: _____
Cigarettes Cigars Pipe How many years? _____
Everyday Someday
Smokeless Tobacco? Yes No Snuff Chew
Are you an ex-tobacco user? Yes No If yes, when did you quit? _____
Are you ready to quit? Yes No
Are you interested in smoking cessation counseling? Yes No

Alcohol Use: Yes No
Use/Week _____ Amount of alcohol/Week _____ (oz.)

Sexual Activity: No Yes Not currently
Partners: Female Male
Birth Control: Condom Oral Other: _____

Advanced Directives:

Living Will or Power of Attorney Surrogate Designation (name/relation): _____
Interested in Advanced Directive Information

E. PREFERRED LABORATORY Quest Labcorp

(Location: Street and city): _____

F. ALLERGIES Please list all medications to which you are allergic. Include any reactions you have had to x-ray dyes (iodine)

MEDICATION	TYPE OF REACTION

G. MEDICATIONS List any medications you are now taking (including vitamins and all non-prescription drugs). Copy names and dosages of medication from the prescription label. Please bring all medications with you to your first visit.

NAME OF MEDICATION	DOSE (MGS, tablets)	How Often

H. PREFERRED PHARMACY:

Name of Local Pharmacy: _____
 Address/Location of Pharmacy: _____
 Phone number: _____
 Mail Order Pharmacy Name: _____
 Mail Order Pharmacy Phone Number: _____
 Mail Order Pharmacy Fax Phone Number: _____
 Mail Order Pharmacy ID #: _____

I. PAST MEDICAL HISTORY

Adult Illnesses: Have you ever had any of the following? (Please check)

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> PVD |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Infertility | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Sexually Transmitted Infection (STI) |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> CAD | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lupus | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | |

Other: _____

J. PAST SURGICAL HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Aneurysm Repair | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Prostate Surgery |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Small Intestine Surgery |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Stone Surgery |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Testical Removal |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Kidney Removal | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Carotid Artery Angioplasty/Stent | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Lithotripsy (ESWL) | <input type="checkbox"/> Urinary Diversion |
| <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Oophorectomy | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Penile Surgery | <input type="checkbox"/> Vasectomy |

Other: _____

K. FAMILY HISTORY

- | | | | |
|--|------------------------------|------------------------------|--------------|
| <input type="checkbox"/> Anesthesia Problems | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Clotting Disorder | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Heart Disease | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Hypertension | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Kidney Cancer | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Prostate Cancer | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Kidney Disease | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Diabetes | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Urolithiasis (Urinary Stones) | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Stoke | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Depression | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> Alcohol Abuse | Mom <input type="checkbox"/> | Dad <input type="checkbox"/> | Other: _____ |

Other Family History: _____

L. REVIEW OF SYSTEMS In the last three (3) months, have you experienced any of the following:

Constitutional

	Yes	IF "YES" PLEASE EXPLAIN
Activity Change	<input type="checkbox"/>	_____
Appetite Change	<input type="checkbox"/>	_____
Chills	<input type="checkbox"/>	_____
Diaphoresis	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	_____
Fever	<input type="checkbox"/>	_____
Weight Change	<input type="checkbox"/>	_____

HENT

Congestion	<input type="checkbox"/>	_____
Dental Problems	<input type="checkbox"/>	_____
Drooling	<input type="checkbox"/>	_____
Ear Discharge	<input type="checkbox"/>	_____
Ear Pain	<input type="checkbox"/>	_____
Facial Swelling	<input type="checkbox"/>	_____
Hearing Loss	<input type="checkbox"/>	_____
Mouth Sores	<input type="checkbox"/>	_____
Nose Bleeds	<input type="checkbox"/>	_____
Post Nasal Drip	<input type="checkbox"/>	_____
Rhinorrhea	<input type="checkbox"/>	_____
Sinus Pressure	<input type="checkbox"/>	_____
Sneezing	<input type="checkbox"/>	_____
Sore Throat	<input type="checkbox"/>	_____
Tinnitus	<input type="checkbox"/>	_____
Swallowing Issue	<input type="checkbox"/>	_____
Voice Change	<input type="checkbox"/>	_____

Endocrine

	Yes	IF "YES" PLEASE EXPLAIN
Cold Intolerance	<input type="checkbox"/>	_____
Heat Intolerance	<input type="checkbox"/>	_____
Polydipsia	<input type="checkbox"/>	_____
Polyphagia	<input type="checkbox"/>	_____
Polyuria	<input type="checkbox"/>	_____

Eyes

	Yes	IF "YES" PLEASE EXPLAIN
Eye Discharge	<input type="checkbox"/>	_____
Eye Itching	<input type="checkbox"/>	_____
Eye Pain	<input type="checkbox"/>	_____
Eye Redness	<input type="checkbox"/>	_____
Photophobia	<input type="checkbox"/>	_____
Visual Disturbance	<input type="checkbox"/>	_____

Respiratory:

Apnea	<input type="checkbox"/>	_____
Chest Tightness	<input type="checkbox"/>	_____
Choking	<input type="checkbox"/>	_____
Cough	<input type="checkbox"/>	_____
Short of Breath	<input type="checkbox"/>	_____
Stridor	<input type="checkbox"/>	_____
Wheezing	<input type="checkbox"/>	_____

Cardiovascular

Chest Pain	<input type="checkbox"/>	_____
Leg Swelling	<input type="checkbox"/>	_____
Palpitation	<input type="checkbox"/>	_____

GI /Abdomen

Distention	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	_____
Anal Bleeding	<input type="checkbox"/>	_____
Blood in Stool	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	_____
Nausea	<input type="checkbox"/>	_____
Rectal Pain	<input type="checkbox"/>	_____
Vomiting	<input type="checkbox"/>	_____

Allergy/Immunology

	Yes	IF "YES" PLEASE EXPLAIN
Environmental	<input type="checkbox"/>	_____
Food	<input type="checkbox"/>	_____
Immunocompromised	<input type="checkbox"/>	_____

L. REVIEW OF SYSTEMS In the last three (3) months, have you experienced any of the following:

	Yes	IF "YES" PLEASE EXPLAIN
Female GU		
Difficult Urination	<input type="checkbox"/>	_____
Dyspareunia	<input type="checkbox"/>	_____
Dysuria	<input type="checkbox"/>	_____
Enuresis	<input type="checkbox"/>	_____
Flank Pain	<input type="checkbox"/>	_____
Frequency	<input type="checkbox"/>	_____
Genital Sore	<input type="checkbox"/>	_____
Hematuria	<input type="checkbox"/>	_____
Menstrual Problem	<input type="checkbox"/>	_____
Pelvic Pain	<input type="checkbox"/>	_____
Urgency	<input type="checkbox"/>	_____
Urine Decreased	<input type="checkbox"/>	_____
Vaginal Bleeding	<input type="checkbox"/>	_____
Vaginal Discharge	<input type="checkbox"/>	_____
Vaginal Pain	<input type="checkbox"/>	_____

Male GU		
Difficult Urination	<input type="checkbox"/>	_____
Dysuria	<input type="checkbox"/>	_____
Enuresis	<input type="checkbox"/>	_____
Flank Pain	<input type="checkbox"/>	_____
Frequency	<input type="checkbox"/>	_____
Genital Sore	<input type="checkbox"/>	_____
Hematuria	<input type="checkbox"/>	_____
Penile Discharge	<input type="checkbox"/>	_____
Penile Pain	<input type="checkbox"/>	_____
Penile Swelling	<input type="checkbox"/>	_____
Scrotal Swelling	<input type="checkbox"/>	_____
Testicular Pain	<input type="checkbox"/>	_____
Urgency	<input type="checkbox"/>	_____
Urine Decrease	<input type="checkbox"/>	_____

Miscellaneous		
Arthralgia	<input type="checkbox"/>	_____
Back Pain	<input type="checkbox"/>	_____
Gate Problem	<input type="checkbox"/>	_____
Joint Swelling	<input type="checkbox"/>	_____
Neck Pain	<input type="checkbox"/>	_____
Neck Stiffness	<input type="checkbox"/>	_____

	Yes	IF "YES" PLEASE EXPLAIN
Neurological		
Dizziness	<input type="checkbox"/>	_____
Facial Asymmetry	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	_____
Lightheadedness	<input type="checkbox"/>	_____
Numbness	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	_____
Speech Difficulty	<input type="checkbox"/>	_____
Syncope	<input type="checkbox"/>	_____
Tremors	<input type="checkbox"/>	_____
Weakness	<input type="checkbox"/>	_____

Hematologic		
Adenopathy	<input type="checkbox"/>	_____
Bruise/Bleed Easy	<input type="checkbox"/>	_____

Psychiatric		
Agitation	<input type="checkbox"/>	_____
Behavior Problem	<input type="checkbox"/>	_____
Confusion	<input type="checkbox"/>	_____
Low Concentration	<input type="checkbox"/>	_____
Dysphoric Mood	<input type="checkbox"/>	_____
Hallucinations	<input type="checkbox"/>	_____
Hyperactive	<input type="checkbox"/>	_____
Nervous/Anxious	<input type="checkbox"/>	_____
Self Injury	<input type="checkbox"/>	_____
Sleep Disturbance	<input type="checkbox"/>	_____
Suicidal Ideas	<input type="checkbox"/>	_____

Skin		
Color Change	<input type="checkbox"/>	_____
Pallor	<input type="checkbox"/>	_____
Rash	<input type="checkbox"/>	_____
Wound	<input type="checkbox"/>	_____

American Urological Association System Score Sheet (AUASS)

OVER THE PAST MONTH OR SO... (Check the appropriate number):

<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)	<input type="checkbox"/> (5)
Almost never	Some of the time	Less than half the time	Half of the time	More than half the time	Almost always

1. How often have you had a sensation of not emptying your bladder completely after you finished urinating?

(0) (1) (2) (3) (4) (5)

2. How often have you had to urinate again less than 2 hours after you finished urinating?

(0) (1) (2) (3) (4) (5)

3. How often have you found you stopped and started again several times when you urinated?

(0) (1) (2) (3) (4) (5)

4. How often have you found it difficult to postpone urination?

(0) (1) (2) (3) (4) (5)

5. How often have you had a weak stream?

(0) (1) (2) (3) (4) (5)

6. How often have you had to push or strain to begin urination?

(0) (1) (2) (3) (4) (5)

7. How MANY times did you typically get up at night to urinate from the time you went to bed until getting up?

(0) (1) (2) (3) (4) (5)

Bother = Sum of Question 1-7 _____

Quality of life due to urinary problems

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 it?
Circle one

- | | |
|---|-------------------------|
| (1) Delighted | (5) Mostly dissatisfied |
| (2) Pleased | (6) Unhappy |
| (3) Mostly Satisfied | (7) Terrible |
| (4) Mixed (about equally
satisfied and dissatisfied) | |

AFFIX PATIENT LABEL HERE



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:

		Very Low	Low	Moderate	High	Very High
1. How do you rate your confidence that you could get and keep an erection?		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?	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