PATIENT HEALTH QUESTIONNAIRE: Urology

Patient Name: _____ **Sex**: ☐ M ☐ F
Last, First, Middle Initial

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. <u>ALLERGIES</u> 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. <u>MEDICATIONS</u> 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)

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

Other: _____

J. PAST SURGICAL HISTORY

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

Other: _____
_____
_____

K. FAMILY HISTORY

☐ Anesthesia Problems	Mom ☐	Dad ☐	Other: _____
☐ Clotting Disorder	Mom ☐	Dad ☐	Other: _____
☐ Heart Disease	Mom ☐	Dad ☐	Other: _____
☐ Hypertension	Mom ☐	Dad ☐	Other: _____
☐ Kidney Cancer	Mom ☐	Dad ☐	Other: _____
☐ Prostate Cancer	Mom ☐	Dad ☐	Other: _____
☐ Kidney Disease	Mom ☐	Dad ☐	Other: _____
☐ Diabetes	Mom ☐	Dad ☐	Other: _____
☐ Urolithiasis (Urinary Stones)	Mom ☐	Dad ☐	Other: _____
☐ Stoke	Mom ☐	Dad ☐	Other: _____
☐ Depression	Mom ☐	Dad ☐	Other: _____
☐ Alcohol Abuse	Mom ☐	Dad ☐	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	☐	_____
Appetite Change	☐	_____
Chills	☐	_____
Diaphoresis	☐	_____
Fatigue	☐	_____
Fever	☐	_____
Weight Change	☐	_____

Eyes

	Yes	IF "YES" PLEASE EXPLAIN
Eye Discharge	☐	_____
Eye Itching	☐	_____
Eye Pain	☐	_____
Eye Redness	☐	_____
Photophobia	☐	_____
Visual Disturbance	☐	_____

HENT

Congestion	☐	_____
Dental Problems	☐	_____
Drooling	☐	_____
Ear Discharge	☐	_____
Ear Pain	☐	_____
Facial Swelling	☐	_____
Hearing Loss	☐	_____
Mouth Sores	☐	_____
Nose Bleeds	☐	_____
Post Nasal Drip	☐	_____
Rhinorrhea	☐	_____
Sinus Pressure	☐	_____
Sneezing	☐	_____
Sore Throat	☐	_____
Tinnitus	☐	_____
Swallowing Issue	☐	_____
Voice Change	☐	_____

Respiratory:

Apnea	☐	_____
Chest Tightness	☐	_____
Choking	☐	_____
Cough	☐	_____
Short of Breath	☐	_____
Stridor	☐	_____
Wheezing	☐	_____

Cardiovascular

Chest Pain	☐	_____
Leg Swelling	☐	_____
Palpitation	☐	_____

GI /Abdomen

Distention	☐	_____
Pain	☐	_____
Anal Bleeding	☐	_____
Blood in Stool	☐	_____
Constipation	☐	_____
Diarrhea	☐	_____
Nausea	☐	_____
Rectal Pain	☐	_____
Vomiting	☐	_____

Endocrine

	Yes	IF "YES" PLEASE EXPLAIN
Cold Intolerance	☐	_____
Heat Intolerance	☐	_____
Polydipsia	☐	_____
Polyphagia	☐	_____
Polyuria	☐	_____

Allergy/Immunology

		IF "YES" PLEASE EXPLAIN
Environmental	☐	_____
Food	☐	_____
Immunocompromised	☐	_____

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	☐	_____
Dyspareunia	☐	_____
Dysuria	☐	_____
Enuresis	☐	_____
Flank Pain	☐	_____
Frequency	☐	_____
Genital Sore	☐	_____
Hematuria	☐	_____
Menstrual Problem	☐	_____
Pelvic Pain	☐	_____
Urgency	☐	_____
Urine Decreased	☐	_____
Vaginal Bleeding	☐	_____
Vaginal Discharge	☐	_____
Vaginal Pain	☐	_____
Male GU		
Difficult Urination	☐	_____
Dysuria	☐	_____
Enuresis	☐	_____
Flank Pain	☐	_____
Frequency	☐	_____
Genital Sore	☐	_____
Hematuria	☐	_____
Penile Discharge	☐	_____
Penile Pain	☐	_____
Penile Swelling	☐	_____
Scrotal Swelling	☐	_____
Testicular Pain	☐	_____
Urgency	☐	_____
Urine Decrease	☐	_____
Miscellaneous		
Arthralgia	☐	_____
Back Pain	☐	_____
Gate Problem	☐	_____
Joint Swelling	☐	_____
Neck Pain	☐	_____
Neck Stiffness	☐	_____

	Yes	IF "YES" PLEASE EXPLAIN
Neurological		
Dizziness	☐	_____
Facial Asymmetry	☐	_____
Headaches	☐	_____
Lightheadedness	☐	_____
Numbness	☐	_____
Seizures	☐	_____
Speech Difficulty	☐	_____
Syncope	☐	_____
Tremors	☐	_____
Weakness	☐	_____
Hematologic		
Adenopathy	☐	_____
Bruise/Bleed Easy	☐	_____
Psychiatric		
Agitation	☐	_____
Behavior Problem	☐	_____
Confusion	☐	_____
Low Concentration	☐	_____
Dysphoric Mood	☐	_____
Hallucinations	☐	_____
Hyperactive	☐	_____
Nervous/Anxious	☐	_____
Self Injury	☐	_____
Sleep Disturbance	☐	_____
Suicidal Ideas	☐	_____
Skin		
Color Change	☐	_____
Pallor	☐	_____
Rash	☐	_____
Wound	☐	_____

American Urological Association System Score Sheet (AUASS)

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

☐ (0)	☐ (1)	☐ (2)	☐ (3)	☐ (4)	☐ (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
(2) Pleased
(3) Mostly Satisfied
(4) Mixed (about equally satisfied and dissatisfied)
(5) Mostly dissatisfied
(6) Unhappy
(7) Terrible

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:

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?	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**