Date: _____

Southeast Texas Urology Associates, L.L.P.

Referring/Primary Physician: _____

Name: _____ Social Security #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: M / F Marital Status (circle one) S M D W

Race: _____ Ethnicity: _____ Preferred Language: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Do you want access to your patient portal? Y N

Emergency Contact: Name: _____ Relationship: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

May the physician discuss your medical history with this person? Y N

Emergency Contact (2): Name: _____ Relationship: _____

Phone #: _____

May the physician discuss your medical history with this person? Y N

Responsible Party Information (if different from patient):

Name: _____ Relationship: _____

Date of Birth: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance Company: _____

Secondary Insurance Company: _____

It will be my responsibility to call for results and all lab and x-rays through this office if not informed in a timely manner.

Signature _____

I authorize all medical and/or surgical treatment to be rendered by Dr. J. Denton Harris, Dr. John Henderson, Dr. Steven A. Socher, Dr. Jenny Nguyen, Benjamin Strahan, FNP-C and Anthony Scoggins, ACNP-BC and I assume financial responsibility. I assign all benefits to be paid to Southeast Texas Urology Associates - Dr. J. Denton Harris, Dr. John Henderson, Dr. Steven A. Socher, Dr. Jenny Nguyen, Benjamin Strahan, FNP-C and Anthony Scoggins, ACNP-BC under my medical Insurance Program and give my authorization to release records if necessary, including DX and treatment to Insurance Company, physicians, etc. I understand that I am entitled to receive a copy of my medical records.

Signature _____

Appointment Type: (Circle) NEW PATIENT FOLLOW UP **Date**_____

Account#_____

Patient Name: _____ **DOB:** _____ **Age:** _____

Height: _____ **Weight:** _____

Reason for today's visit:_____

_____

How long have you had these symptoms? _____

1. Primary Doctor _____ Preferred Pharmacy _____ Mail Order:_____
2. Are you presently taking: (Circle) Coumadin - Aspirin- Ecotrin - Persantine - Glucophage
   Inhalers - Ticlid - Plavix - St. John's Wort
3. Have you had a: (Circle One) Heart Attack **Yes/No** Stroke **Yes/No**
   Diabetes **Yes/No** Emphysema/Asthma **Yes/No**
4. Other Medical Problems _____
5. List previous surgeries_____

   _____
6. Allergies _____

   Family History of: (Please Circle)

   Prostate Cancer **Yes/No** Kidney Cancer **Yes/No** Bladder Cancer **Yes/No**

   Kidney Stones **Yes/No** Kidney Problems **Yes/No**
7. Occupation: _____
8. Tobacco Use: (Please Circle) Cigarettes/Cigar **Yes/No** Dipping/Chewing **Yes/No**

   Did you ever smoke? **Yes/ No** When did you quit?_____ How Long did you smoke:_____
9. Do you drink Alcohol? (Please Circle) **Yes/ No** **Social Light or Moderate**
10. Pneumonia Immunization? (Please Circle) **Yes / No** When? _____
11. Last colonoscopy? _____

Please Circle Yes or No to Each Symptom

Y/N Burning Upon Urination	Y/N Urgency to Urinate	Y/N Weight Loss
Y/N Discharge from Penis	Y/N Weak Stream	Y/N Weight Gain
Y/N Blood in Urine	Y/N Straining to Urinate	Y/N Loss of Sexual Interest
Y/N Blood in Semen	Y/N Foul Smelling Urine	Y/N Loss of Erection
Y/N Leaking of Urine (incontinence)	Y/N Lesions on Penis	Y/N Curvature of Erection
Y/N Pelvic Pain	Y/N Air Coming Out of Penis	Y/N Double Vision
Y/N Back Pain	Y/N Urination at Night	Y/N Blurry Vision
Y/N Sore Muscles	Y/N Constipation	Y/N Cataracts
Y/N Arthritis	Y/N Diarrhea	Y/N Glaucoma
Y/N Joint Problems	Y/N Nausea	Y/N Blind
Y/N Kidney Pain	Y/N Vomiting	Y/N Skin Rash
Y/N Abdominal Pain	Y/N Reflux	Y/N Dry Skin
Y/N Incomplete Emptying of Bladder	Y/N Fever	Y/N Bruising
Y/N Frequency of Urination	Y/N Chills	Y/N Lesions/Ulcers
Y/N Difficulty Starting Urine Flow	Y/N Night Sweats	Y/N Shortness of Breath
Y/N Joint Problems	Y/N Hearing Loss	Y/N Wheezing
Y/N Varicose Veins	Y/N Nasal Stuffiness	Y/N Cough
Y/N Hepatitis	Y/N Dry Mouth	Y/N Chest Pain
Y/N Swelling of Legs	Y/N Sore Throat	Y/N Swollen Glands
Y/N Dizziness	Y/N Forgetfulness	Y/N Bleeds Easily
Y/N Migraines	Y/N Loss of Balance	Y/N Blood Clots
Y/N Depression	Y/N Irregular Heartbeat	Y/N Change in Bowels

Current Medications:

_____
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International Prostate Symptom Score (IPSS)

Patient Name: Date of Birth: Today's Date:

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 discontinue your BPH medications?	Yes	No

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 (MUCHMORE 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 (MUCHMORE 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 (MUCHMORE 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**