SPRINGS UROLOGY

1725 N University Dr, Suite 400 • Coral Springs, FL 33071
Office 954.752.3166 • Fax 954.753.5628
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AARON BRAFMAN, M.D.
BLAKE EVANS, M.D.

PATIENT HISTORY FORM

DATE: _____

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: _____ SECONDARY PHONE NUMBER: _____

EMAIL:

REASONS FOR TODAY'S VISIT: _____

PRIMARY DOCTOR & PHONE #: _____

REFERRING DOCTOR: _____

PHARMACY NAME & PHONE #: _____

DRUG ALLERGIES

□ NONE

DRUG	REACTION
_____	_____
_____	_____
_____	_____

MEDICATION

LIST ALL INCLUDING OVER THE COUNTER □ NONE

NAME OF DRUG	DOSE	# TIMES PER DAY	NAME OF DRUG	DOSE	# TIMES PER DAY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ARE YOU TAKING ANY BLOOD THINNERS? (CHECK ALL THAT APPLY) □ YES □ NO

□ ASPIRIN □ COUMADIN □ WARFARIN □ ELIQUIS □ XARELTO □ PRADAXA □ PLAVIX □ AGGRENOX □ BRILINTA

□ OTHER_____

			DATE
DID YOU GET A FLU SHOT THIS YEAR?	□ YES	□ NO	_____
DID YOU GET A PNEUMOCOCCAL VACCINE?	□ YES	□ NO	_____
ADMINISTERED BY_____			
HAVE YOU HAD A RECENT COLONOSCOPY?	□ YES	□ NO	_____

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PAST SURGICAL HISTORY

□ APPENDECTOMY
□ BACK SURGERY
□ C-SECTION
□ CABG (CORONARY BYPASS)
□ CHOLECYSTECTOMY
□ COLON RESECTION
□ COLONOSCOPY DATE: _____
□ GASTRIC BYPASS
□ HEMORRHOIDECTOMY
□ HERNIA REPAIR
□ HIP REPLACEMENT
□ HYSTERECTOMY
□ NEPHRECTOMY
□ PACEMAKER IMPLANT
□ PROSTATECTOMY
□ SPLENECTOMY
□ THYROIDECTOMY
□ TURP
□ VASECTOMY

PAST MEDICAL HISTORY

□ ALZHEIMER'S DISEASE
□ ANEMIA
□ ANXIETY DISORDER
□ ARTHRITIS
□ ASTHMA
□ BLEEDING DISORDERS
□ CARDIAC ARRHYTHMIA
□ CONGESTIVE HEART DISEASE
□ COPD (LUNG DISEASE)
□ CORONARY HEART DISEASE
□ DEPRESSION
□ DIABETES MELLITUS
□ DVT (VENOUS EMBOLISM)
□ ELEVATED CHOLESTEROL
□ ESOPHAGEAL REFLUX
□ FIBROMYALGIA
□ GLAUCOMA (OPEN/CLOSED)
□ HEART ATTACK (MI)
□ HEPATITIS
□ HERNIA
□ HYPERTENSION
□ HYPERTHYROIDISM
□ HYPOTHYROIDISM
□ IRRITABLE BOWEL DZ
□ KIDNEY STONE
□ MIGRAINE / HEADACHE
□ OSTEOPOROSIS
□ SEIZURE
□ STROKE (CVA)
□ TRANSIENT ISCHEMIC ATTACK (TIA)

□ CANCER (LIST ALL):

_____

FAMILY HISTORY (PLEASE SPECIFY FAMILY MEMBER)

BLADDER CANCER	□ YES	□ NO	_____	DIABETES	□ YES	□ NO	_____
BREAST CANCER	□ YES	□ NO	_____	HEART DISEASE	□ YES	□ NO	_____
CERVICAL CANCER	□ YES	□ NO	_____	HYPERTENSION	□ YES	□ NO	_____
KIDNEY CANCER	□ YES	□ NO	_____	KIDNEY STONES	□ YES	□ NO	_____
OVARIAN CANCER	□ YES	□ NO	_____	OTHER	□ YES	□ NO	_____
PROSTATE CANCER	□ YES	□ NO	_____	OTHER	□ YES	□ NO	_____
UTERINE CANCER	□ YES	□ NO	_____	OTHER	□ YES	□ NO	_____

SOCIAL HISTORY

MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

TOBACCO USE: □ NON SMOKER □ SMOKER _____ PACKS/DAY ____ YEARS □ PREVIOUS SMOKER – QUIT

ALCOHOL USE: □ NON DRINKER □ SOCIAL □ DRINKER ____ DRINKS/DAY

HOW MANY CAFFEINATED DRINKS PER DAY? 0 1 2 3 4 5+

HEIGHT: _____ FEET _____ INCHES WEIGHT: _____ LBS

USUAL BLOOD PRESSURE READING _____

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CONSTITUTIONAL

FEVER	□ YES	□ NO
CHILLS	□ YES	□ NO
HOT FLASHES	□ YES	□ NO
FATIGUE	□ YES	□ NO
WEIGHT LOSS	□ YES	□ NO
WEIGHT GAIN	□ YES	□ NO
WEAKNESS	□ YES	□ NO
LOSS OF APPETITE	□ YES	□ NO

OPHTHALMOLOGY

CATARACTS	□ YES	□ NO
GLAUCOMA	□ YES	□ NO
BLURRY VISION	□ YES	□ NO
DRY EYES	□ YES	□ NO
VISION LOSS	□ YES	□ NO

ENT

TINNITIS (RINGING IN EAR)	□ YES	□ NO
HEARING LOSS / DIFFICULTY HEARING	□ YES	□ NO
SINUS PROBLEMS	□ YES	□ NO
NOSE BLEEDS	□ YES	□ NO
DRY MOUTH	□ YES	□ NO
DIFFICULTY SWALLOWING	□ YES	□ NO
SORE THROAT	□ YES	□ NO

CARDIOLOGY

SWELLING OF ANKLES	□ YES	□ NO
CHEST PAIN	□ YES	□ NO
DIZZINESS	□ YES	□ NO
IRREGULAR HEARTBEAT	□ YES	□ NO
PALPITATIONS	□ YES	□ NO

RESPIRATORY

SHORTNESS OF BREATH	□ YES	□ NO
WHEEZING	□ YES	□ NO
COUGH	□ YES	□ NO

GASTROENTEROLOGY

ABDOMINAL PAIN	□ YES	□ NO
CONSTIPATION	□ YES	□ NO
DIARRHEA	□ YES	□ NO
NAUSEA / VOMITING	□ YES	□ NO
HEARTBURN / INDIGESTION	□ YES	□ NO
BLOOD IN STOOL	□ YES	□ NO

MUSCULOSKELETAL

FLANK PAIN	□ YES	□ NO
BACK PAIN	□ YES	□ NO
SORE MUSCLES	□ YES	□ NO
JOINT SWELLING, STIFFNESS, PAIN	□ YES	□ NO

UROLOGIC

NIGHTTIME URINATION	□ YES	□ NO
DIFFICULTY STARTING STREAM	□ YES	□ NO
WEAK STREAM	□ YES	□ NO
LEAKAGE OR DRIBBLING	□ YES	□ NO
PAINFUL URINATION	□ YES	□ NO
BLOOD IN URINE	□ YES	□ NO
FREQUENT URINATION	□ YES	□ NO
URGENT URINATION	□ YES	□ NO
INCOMPLETE BLADDER EMPTYING	□ YES	□ NO

GYNECOLOGIC

POST MENOPAUSAL	□ YES	□ NO
ON HORMONE REPLACEMENT?	□ YES	□ NO
VAGINAL DRYNESS	□ YES	□ NO
VAGINAL PAIN	□ YES	□ NO
VAGINAL DISCHARGE	□ YES	□ NO
VAGINAL ITCHING	□ YES	□ NO
PAIN WITH SEX	□ YES	□ NO

MALE REPRODUCTIVE

DIFFICULTY WITH ERECTION	□ YES	□ NO
PAIN WITH ERECTION	□ YES	□ NO
DIFFICULTY WITH EJACULATION	□ YES	□ NO
DIMINISHED SEXUAL DRIVE	□ YES	□ NO
PENILE PAIN	□ YES	□ NO
PENILE CURVATURE	□ YES	□ NO
TESTICULAR PAIN	□ YES	□ NO

ENDOCRINE

EXCESSIVE THIRST	□ YES	□ NO
EXCESSIVE URINATION	□ YES	□ NO
COLD INTOLERANCE	□ YES	□ NO
HEAT INTOLERANCE	□ YES	□ NO

HEMATOLOGIC / LYMPHATIC

BRUISES EASILY	□ YES	□ NO
SWOLLEN LYMPH NODES	□ YES	□ NO
BLOOD CLOTTING PROBLEM	□ YES	□ NO

DERMATOLOGY

RASH / ITCHING	□ YES	□ NO
DRY OR SENSITIVE SKIN	□ YES	□ NO
SKIN CANCER	□ YES	□ NO

NEUROLOGY

HEADACHE	□ YES	□ NO
NUMBNESS / TINGLING	□ YES	□ NO
WEAKNESS	□ YES	□ NO
DIZZINESS	□ YES	□ NO
SEIZURES / CONVULSIONS	□ YES	□ NO
ANXIETY / DEPRESSION	□ YES	□ NO

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AUA Symptom Score (AUASS)

Patient Name: _____

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 halfthe 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 AUA 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 medications?	Yes	No

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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**

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Cancellation / No Show Fee

We understand that you may sometimes need to reschedule appointments.

You will incur a fee if you cancel within 48 hours or do not show up for your visit.

$25 for Office visits

$50 for Diagnostic procedures or tests

Thank you for your understanding.

_____ _____

Patient Signature **Date**

_____

Patient Name