ISLAND UROLOGY
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Anacortes, WA 98221
(360) 299-4980

Dear ________________________________,

It is our pleasure to welcome you to our practice. We are sending you some information prior to your appointment in order for your first visit to be as efficient as possible. Please fill out the patient data sheet and health history form and bring them with you. We will also need a urine specimen at the time of your visit, so please do not empty your bladder before your appointment!

Your appointment is scheduled for _______________________ at _______________.

Please check in at ______________.

Please be sure to have your insurance information with you for this appointment. If your insurance requires a co-pay, we ask that you pay it at the time of service. If a referral authorization is required, please make sure you contact your primary care provider prior to your scheduled visit. All self-pay patients will be required to pay for the visit in full at the time of service

If you have any questions, please call our office at (360) 299-4980.

Sincerely,
Island Urology

ISLAND HOSPITAL

UROLOGY – ADULT HEALTH HISTORY FORM

Island Urology
1015 25th Street, Upper Level
Anacortes, WA 98221
(360) 299-4980

Patient Name: ______________________________ **Phone:** ______________

Age: _________ **Date of Birth:** _________________ **Height:** ______ft _____in **Weight:** _________lbs

Referring Provider: ______________________________ **Phone:** ______________

Primary Care Provider: ______________________________ **Phone:** ______________

Sex: ☐ M ☐ F **Race:** ☐ White ☐ Black ☐ Asian ☐ Hispanic/Latino ☐ Other ______________

Reason for Visit Today: ______________________________

Pharmacy Name: ______________ **City:** ______________ **Phone:** ______________

Drug Allergies: ______________________________

Other Allergies: ______________________________

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely.

Name of Drug or Supplement	Strength (mg)	How often (# of times per day)

MEDICAL HISTORY: Please check any of the following conditions which **YOU** have had or presently have:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ BPH
- ☐ Cancer
  Type: ___________
- ☐ Chest Pain
- ☐ CVA (Stroke)
- ☐ Chronic UTIs
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ GERD
- ☐ Gout
- ☐ Hepatitis C
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ High Blood Pressure
- ☐ Inflammatory Bowel
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Heart Attack
- ☐ Neurologic Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Renal/Kidney Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Thyroid Disease
- ☐ Valvular Heart Disease

FEMALES ONLY: **Date of last menstrual period:** ______/______/______ **Date of last PAP smear:** ____/______/______

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure:

	Yr		Yr		Yr	**FEMALES Only**	Yr	**MALES Only**	Yr
☐ Adrenalectomy		☐ Cystoscopy		☐ Liver Biopsy		☐ Bladder Suspension		☐ Brachytherapy	
☐ Appendectomy		☐ ESWL		☐ Kidney Removed		☐ Breast Biopsy		☐ Circumcision	
☐ Back Surgery		☐ Gastric Bypass		☐ Pacemaker		☐ C-Section		☐ Hydrocelectomy	
☐ Bladder Augmentation		☐ Hernia Repair		☐ Perc Stone Removal		☐ Abdominal Hyst		☐ Laser of Prostate	
☐ CABG		Type:__________		☐ Kidney Stone Removal		☐ Mastectomy		☐ Orchiectomy	
☐ Gallbladder		__________		☐ Ureteral Stents		☐ Vaginal Sling		☐ Penile Prosthesis	
☐ Colectomy		☐ Hip Replacement		**Other:**		☐ TAH / BSO		☐ Prostate Biopsy	
☐ Colon Surgery		☐ Knee Replacement		☐		☐ Tubal Ligation		☐ Prostatectomy	
☐ Coronary Stent		☐ Laparoscopy		☐		☐ Vaginal Hyst		☐ Spermatocelectomy	
☐ Bladder Removal		☐ Lithotripsy		☐				☐ TURP	
								☐ Varicocele Ligation	
								☐ Vasectomy	

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UROLOGY – ADULT HEALTH HISTORY FORM

CHRONIC PROBLEMS LIST: Please list any chronic health problems you have.

Problem	Date of onset	Treatment

FAMILY HISTORY: Please check any of the following conditions that apply to your family members and list their relation to you.

Diagnosis	Yes	No	Relationship	Diagnosis	Yes	No	Relationship
Blood Disease				High Cholesterol			
BPH				High Blood Pressure			
Cancer				Inflammatory Bowel Disease			
Type:				Migraines			
CVA / Stroke				Renal Failure			
Coronary Artery Disease				Seizure Disorder			
Diabetes				Thyroid Disorder			
Eczema				Urinary Tract Infections			
Gout				Kidney Stones			
Hearing Impairment				Other:			
Other:							

Marital / Family Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed Previously widowed? ☐ Yes ☐ No Previous divorce? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No If yes, number: __________

LIFESTYLE:

Occupation: ______________________________

Exercise? ☐ Yes ☐ No If yes, type: __________________ Frequency: ___________per_________ Hours per week:___________

TOBACCO:

Uses tobacco? ☐ Yes ☐ No ☐ Former Tobacco type: _________________ Units per day: _________ Number of years:_______

If former user: Units per day: _________ Number of years: ______ Year quit: _________

CAFFEINE: ☐ Yes ☐ No Type: _____________,_________________ Amount Daily: _________________

ALCOHOL: ☐ Yes ☐ No ☐ Formerly, Year quit: ________ Type: _________________ Frequency: ________________

Amount: _______per________ Last drink: _____________

REVIEW OF SYSTEMS: Please mark all Yes or No

Constitutional-☐Neg	Respiratory-☐Neg	Gastrointestinal-☐Neg	Metabolic/Endocrine-☐Neg	Musculoskeletal-☐Neg
No Yes	No Yes	No Yes	No Yes	No Yes
☐ ☐ Chills	☐ ☐ Dyspnea (shortness of breath)	☐ ☐ Diarrhea	☐ ☐ Goiter	☐ ☐ Back pain
☐ ☐ Fever				
Heent-☐Neg	**Cardiovascular-☐Neg**	**Integumentary-☐Neg**	**Neurological-☐Neg**	**Hema/Lymphatic-☐Neg**
No Yes	No Yes	No Yes	No Yes	No Yes
☐ ☐ Double vision	☐ ☐ Chest pain	☐ ☐ Rash	☐ ☐ Dizziness	☐ ☐ Easy bleeding
		Psychiatric-☐Neg		☐ ☐ Petechiae/easy bruising
		No Yes		
		☐ ☐ Anxiety		

11 System ROS

☐ **All Negative**

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ISLAND HOSPITAL

UROLOGY – ADULT HEALTH HISTORY FORM

Patient Name: ______________________________ **Phone:** ______________

Patient Address: ____

E-mail Address: ____

Responsible Party/Relationship: ______________________ **Phone:** ______________

Responsible Party Address: ____________________________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Not Provided **Language:** ☐ English ☐ Spanish ☐ Russian ☐ Other

Name of Spouse: __________________________ **Business Phone:** ______________

Emergency Contact: ________________________ **Phone:** ______________

Primary Insurance: ______________________________ **ID #:** ______________

Subscriber: ______________________ **Date of Birth:** __________ **Group #:** __________

Secondary Insurance: ____________________________ **ID #:** ______________

Subscriber: ______________________ **Date of Birth:** __________ **Group #:** __________

Patient ID Sticker

ISLAND HOSPITAL

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

Question						
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?	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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SYMPTOM INDEX FOR BPH

Patient Name: ____ Date of Visit: ________________

Urinary Symptoms	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. Over the past month, how often have you had the sensation that your bladder was not completely empty after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate again less than two hours after you last finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times while urinating?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urinating?	0	1	2	3	4	5
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 or more times**
7. Over the last month, how many times did you typically get up to urinate each night, from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5
TOTAL AUA Symptom Score = Sum of questions 1 – 7	a. 0-7 ___________ Mild b. 8-19 ___________ Moderate c. 20-35 ___________ Severe					

	Delighted	Pleased	Mostly Satisfied	Mixed (about equally satisfied and dissatisfied)	Mostly dissatisfied	Unhappy	Terrible
1. If you had 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

Reference: American Urological Association (AUA) Symptom Index for BPH

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