



ISLAND UROLOGY
Mansel K. Kewitch, M.D., F.A.C.S
1015 25th Street, Upper Level
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 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:

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

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

Health History Form - Urology
Island Hospital

Document Owner: Hildebrand, Krysteena Director Specialty Care Clinics
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Printed copies are for reference only. Please refer to the electronic copy for the latest version

Patient ID Sticker

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

11 System ROS
 All Negative

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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 #: _____

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?	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

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

**Symptom Index for BPH (Benign Prostatic Hyperplasia)
Island Hospital**

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