Parkland Medical Center

Lahey CLINIC

Urology New Patient History Form

One Parkland Drive • Derry, NH 03038 • (603) 432-1500
www.parklandmedicalcenter.com

Name: _____ Height: _____
Birthdate (mm/dd/yyyy): _____ Weight: _____
Age: _____ Referred by: _____
Gender: ☐ Male ☐ Female Primary Care Physician: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?

PAST MEDICAL HISTORY: Please list ***prior and current medical history***, even if your medications have fixed the problem (examples: high blood pressure, high cholesterol, asthma, heart attack, depression, etc).

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

PAST SURGICAL HISTORY: Please ***list prior surgeries with approximate dates***, no matter how long ago (examples: appendectomy, gall bladder removal, tonsillectomy, hip or knee surgery, etc).

OPERATION	*YEAR*	*REASON*
1.		
2.		
3.		
4.		
5.		

Do you have ALLERGIES to medication, food, latex, adhesives? ☐ **Yes** ☐ **No**
If yes, please explain:

List **CURRENT MEDICATIONS:** dosage & frequency (including aspirin, advil, and vitamins)

1. 5.
2. 6.
3. 7.
4. 8.

SOCIAL HISTORY
Marital status: _____
Occupation: _____
Number of children? _____
Do you drink alcohol? ☐ Yes ☐ No
Alcohol intake: ☐ occasional ☐ 1-2 per day ☐ 3-4 per day ☐ 5-6 per day ☐ >6 per day

Do you smoke currently?
If you quit, what year? _____
Prior to quitting, # packs per day? _____
How many years did you smoke? _____
Recreational drug use? ☐ Yes ☐ No

FAMILY HISTORY: List all serious family medical illnesses or cancers (father, mother, siblings, your children). Examples: high blood pressure, stroke, heart attack, diabetes, prostate cancer.

1. 5.
2. 6.
3. 7.
4. 8.

Patient Information/Label

If you are having ***pain related to your visit today***, please rate it by circling on the scale below, with "0" being no pain, and "10" being excruciating pain:

☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

How would you describe the pain? _____

What makes it worse? _____

What makes it better?

OTHER: **Unexpected** weight loss greater than 10#s ☐ Yes ☐ No

Have you fallen in the past 6 months? ☐ Yes ☐ No

I learn better by: ☐ Hearing ☐ Reading ☐ Seeing pictures ☐ All

I have suffered abuse in the last year ☐ Yes ☐ No

I need help with: ☐ Dressing ☐ Bathing ☐ Driving ☐ None

REVIEW OF SYSTEMS

Have you had any of the following in the last 12 months?

CONSTITUTIONAL		
Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Unexpected weight loss	☐ Yes	☐ No
EYES / EARS / NOSE / THROAT		
Blurred or double vision	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Ear infection	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
CARDIOVASCULAR		
Chest pain or angina	☐ Yes	☐ No
Palpitations / irregular beat	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Ankle or foot swelling	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
PULMONARY		
Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Coughing blood	☐ Yes	☐ No
HEMATOLOGICAL		
Anemia	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Easy bleeding	☐ Yes	☐ No
SKIN		
Persistent Itch	☐ Yes	☐ No
New Lesion / Rash	☐ Yes	☐ No
PSYCHOLOGICAL		
Generally happy with life?	☐ Yes	☐ No
Severe depression	☐ Yes	☐ No
Considered suicide	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Difficulty sleeping	☐ Yes	☐ No

GASTROINTESTINAL		
Heartburn / Acid reflux	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Nausea and/or vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
ENDOCRINE		
Excessive thirst	☐ Yes	☐ No
Too hot or too cold	☐ Yes	☐ No
Blood sugar problems	☐ Yes	☐ No
Irregular menstrual cycles	☐ Yes	☐ No
MUSCULOSKELETAL		
Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
NEUROLOGICAL		
Numbness or tingling	☐ Yes	☐ No
Arm/Leg weakness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
GENITOURINARY		
Blood in urine	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Difficult urination	☐ Yes	☐ No
Urinary infection	☐ Yes	☐ No
LYMPHATIC		
Swollen glands	☐ Yes	☐ No
Swelling of arms/legs	☐ Yes	☐ No
ALLERGY / IMMUNOLOGY		
Hay fever	☐ Yes	☐ No
Frequent infections	☐ Yes	☐ No

OTHER

Anything else you would like to add?

Reviewed by: _____ Date/Time: _____

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IIQ and UDI

__ / __ / ____
MM DD YY

Incontinence Impact Questionnaire

Has urine leakage affected your: ("X" one for each question)

	Not at all	Slightly	Moderately	Greatly
1. Ability to do household chores (cooking, housecleaning, laundry)?	☐	☐	☐	☐
2. Physical recreation such as walking swimming or other exercise?	☐	☐	☐	☐
3. Entertainment activities (movies, concerts, etc.)?	☐	☐	☐	☐
4. Ability to travel by car or bus more than 30 minutes from home?	☐	☐	☐	☐
5. Participation in social activities outside your house?	☐	☐	☐	☐
6. Emotional health (nervousness, depression, etc.)?	☐	☐	☐	☐
7. Feeling frustrated?	☐	☐	☐	☐

Urogenital Distress Inventory

Do you experience, and if so, How much are you bothered by: ("X" one for each question)

	Not at all	Slightly	Moderately	Greatly
1. Frequent urination?	☐	☐	☐	☐
2. Urine leakage related to the feeling of urgency?	☐	☐	☐	☐
3. Urine leakage related to physical activity, coughing, or sneezing?	☐	☐	☐	☐
4. Small amounts of urine leakage drops?	☐	☐	☐	☐
5. Difficulty emptying your bladder?	☐	☐	☐	☐
6. Pain or discomfort in the lower abdominal or genital area?	☐	☐	☐	☐

Patient Information/Label

1. Do you have any uncontrolled leakage of gas, liquid, or solid stool?

   ____ Yes ____ No

   If yes, mark which apply

   ____ gas
   ____ liquid stool
   ____ solid stool

2. On a scale of 0 to 100, where zero represents death and 100 represents perfect health, please indicate how you would rate your current state of health.

   ____ ____ ____ Number from 0-100

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AUA Symptom Score (AUASS) and Quality of Life (QOL)

PATIENT NAME: _____ **TODAY'S DATE:** _____

(Circle One Number on Each Line)	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
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
During the past month or so, how often have you found it difficult to postpone urination?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
During the past month or so, how often have you had a weak urinary stream?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
During the past month or so, how often have you had to push or strain to begin urination?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
Over the past month, how many times per night 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?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Add the score for each number above and write the total in the space to the right. TOTAL _____

SYMPTOM SCORE: **1-7 (Mild)** **8-19 (Moderate)** **20-35 (Severe)**

Patient Information/Label

AUA Symptom Score (AUASS) and Quality of Life (QOL)

Quality of Life (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

NAME: _____ **TODAY'S DATE:** _____

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	EXTREMELY DIFFICULT	VERY DIFFICULT	DIFFICULT	SLIGHTLY DIFFICULT	NOT DIFFICULT
	☐ 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**

PATIENT STICKER