

**Patient History Form**

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**Note: Confidential**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**We would like to send a letter to update your referring physician. Yes No**

Referring Physician: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Note: If the telephone number is not provided, no letter will be sent out.**

**Chief Complaint:**

What is the main reason for your office visit today (please describe in detail)?

\_\_\_\_\_

\_\_\_\_\_

**History of Present Sexual Function**

**1. Circle the current level of your interest in sexual relations**

High                      About Right                      Less than it has been before

**2. Erectile Function**

- A. When did your sexual problem start? \_\_\_\_\_
- B. Was the onset sudden or gradual? \_\_\_\_\_
- C. Before the problem, how often did you have intercourse? \_\_\_\_\_
- D. How often do you attempt intercourse now? \_\_\_\_\_
- E. What percent of the time are you able to penetrate? \_\_\_\_\_
- F. When was the last time you were able to penetrate? \_\_\_\_\_
- G. Has the shape of your erect penis changed?                      Yes      No
- H. Are you presently able to have partial erection?                      Yes      No
- I. Do you ever lose your erection during intercourse?                      Yes      No

J. Do you ever ejaculate with a soft penis? Yes No

K. Circle the number that best describes the quality of your erections.

1. Limp penis.
2. Full penis, no hardness, no penetration.
3. Occasional penetration, but no maintaining ability.
4. Sufficient for penetration, but no maintaining ability.
5. Able to penetrate easily and maintain to orgasm.

L. Using the same scale above, circle the number which best describes your erection with masturbation.

1 2 3 4 5 N/A

M. Do you have erections at night? \_\_\_\_\_ On awakening? \_\_\_\_\_

N. How do these erections compare with your sexually induced erections?

Same Better Worse

O. Does your ability to have an erection vary with different partners?

Yes No N/A

## Sexual Health Inventory for Men

### Patient Instructions

This questionnaire is designed to help us quantify and treat your erectile dysfunction. You will be asked to complete this questionnaire in the future to measure the success of the treatment.

#### *Over the past six months:*

1. How do you rate your **confidence** that you can get and keep an erection?
2. When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)?
3. During sexual intercourse, **how often** were you able to maintain your erection after you had entered your partner?
4. During sexual intercourse, **rate your ability** to maintain your erection to completion of intercourse.
5. When you attempted sexual intercourse, **how often** was it satisfactory for you?

0 1 2 3 4 5
0 1 2 3 4 5
0 1 2 3 4 5
0 1 2 3 4 5
0 1 2 3 4 5
<b>Total:</b>

**Add the numbers corresponding to the questions 1-5.**

**Your score:** \_\_\_\_\_

If you scored between **1-7**, you may have severe erectile dysfunction.

If you scored between **8-11**, you may have moderate erectile dysfunction.

If you scored between **12-16**, you may have mild to moderate erectile dysfunction.

If you scored between **17-21**, you may have mild erectile dysfunction.

If you scored between **22-25**, you have normal erectile function.

**3. Climax or Orgasm**

- |  |     |    |
|--|-----|----|
| A. Are you able to have a climax or orgasm?                        | Yes | No |
| B. Does semen (fluid) come out of your penis when you have orgasm? | Yes | No |
| C. If yes, is the amount the same when you have/had erections?     | Yes | No |
| D. Have you noticed any change in the sensitivity of your penis?   | Yes | No |

**4. Sexual History**

- |  |          |            |          |
|--|----------|------------|----------|
| A. Sexual Orientation: Heterosexual                                  | Bisexual | Homosexual |          |
| B. Are you: Married  | Single   | Widowed    | Divorced |
| C. Do you have a regular/steady partner?                             | Yes      | No         |          |
| D. If you are in a relationship:                                     |          |            |          |
| 1. How many years have you been together? _____                      |          |            |          |
| 2. Describe the quality of your relationship: _____                  |          |            |          |
| _____  |          |            |          |
| 3. Describe the quality of your sexual relationship: _____           |          |            |          |
| _____  |          |            |          |
| 4. Does your partner contribute to your sexual dysfunction?          | Yes      | No         |          |
| 5. Is your partner interested in having your sexual problem treated? | Yes      | No         |          |

**5. Past Evaluation of Sexual Function**

- |  |     |    |
|--|-----|----|
| A. Did you ever see a doctor(s) for this problem before? | Yes | No |
| If yes, were there any diagnostic tests performed?       | Yes | No |
| If yes, which ones?                                      |     |    |
| 1. Hormone Blood Level                                   | Yes | No |
| 2. Penile Injection                                      | Yes | No |
| 3. Sleep Test (Neva)                                     | Yes | No |
| 4. Penile Ultrasound (Duplex)                            | Yes | No |
| 5. Other _____   |     |    |
| B. Were you ever treated with pills?                     | Yes | No |
| If yes, which ones?                                      |     |    |
| 1. Viagra 25 50 100 mg                                   | Yes | No |
| Frequency _____ Result _____                             |     |    |
| 2. Cialis 5 10 20 mg                                     | Yes | No |
| Frequency _____ Result _____                             |     |    |
| 3. Levitra 5 10 20 mg                                    | Yes | No |
| Frequency _____ Result _____                             |     |    |
| C. Were you treated with any of the following:           |     |    |
| 1. Urethral suppositories (Muse)?                        | Yes | No |
| 2. Penile Injections?                                    | Yes | No |
| 3. External vacuum device?                               | Yes | No |

6. *Any additional comments:*

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## Past Medical and Social History

1. *Do you have any medical illnesses or conditions?* Yes No

Circle any of the following that apply:

1. High blood pressure
2. High cholesterol levels
3. Heart disease
4. Diabetes

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2. *List all serious illnesses in your immediate family.*

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3. *List any personal treatments and surgeries (operations) and when they occurred.*

Surgery \_\_\_\_\_ Date \_\_\_\_\_

Surgery \_\_\_\_\_ Date \_\_\_\_\_

Surgery \_\_\_\_\_ Date \_\_\_\_\_

Radiation Therapy \_\_\_\_\_ Date \_\_\_\_\_

Chemotherapy \_\_\_\_\_ Date \_\_\_\_\_

4. *Drug Allergies:* Yes No

Please list: \_\_\_\_\_

5. *Medications:* Yes No

Please list all drugs, medications, eye drops, etc.

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Do you take any medications that fall into the category of nitrates? Yes No

Do you carry nitroglycerin with you in case of emergencies? Yes No

Do you use a skin patch for the delivery of medications? Yes No

**6. Alcohol Intake:**

Do you drink alcohol (beer, wine, liquor, etc.)? Yes No

If yes: Type \_\_\_\_\_ Amount \_\_\_\_\_

**7. Tobacco Use:**

Do you or did you ever smoke? Yes No

If yes: How many pack(s) per day? \_\_\_\_\_

For how many years? \_\_\_\_\_

If you stopped, how long ago? \_\_\_\_\_

**8. Psychological History:**

Have you ever consulted a psychiatrist, psychologist, or other psychotherapist?  
Yes No

If yes, please describe the reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Were you diagnosed with any of the following:

Depression? Yes No

Obsessive-compulsive disorder? Yes No

Bipolar disorder? Yes No

Psychosis/Neurosis? Yes No

**Physician's Notes:**

## BENIGN PROSTATE ENLARGEMENT

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
7. Over the last month, how many times did you typically get up to urinate each night, from the time you until the time you got up in the morning?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5 or more times
TOTAL AUA Symptom Score = Sum of questions 1 -7 _____						



**New Patient Questionnaire**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you in advance for filling out this quick survey.

How were you referred to Dr. Eid?

\_\_\_\_\_ Another Doctor  
If so, who referred you? \_\_\_\_\_

\_\_\_\_\_ Newspaper Advertisement  
If so, which newspaper? \_\_\_\_\_

\_\_\_\_\_ Daily News  
\_\_\_\_\_ NY Post  
\_\_\_\_\_ Newsday  
\_\_\_\_\_ Other

\_\_\_\_\_ Newspaper Article  
If so, which newspaper? \_\_\_\_\_

\_\_\_\_\_ Daily News  
\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Internet  
If so, which web site? \_\_\_\_\_

\_\_\_\_\_ Advanced Urological Care Web site  
\_\_\_\_\_ Search Engine  
\_\_\_\_\_ Healthology (ABC News)  
\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Other Publication  
If so, which one? \_\_\_\_\_

\_\_\_\_\_ New York Magazine  
                  "Best Doctors" Issue  
\_\_\_\_\_ Connelly's Guide  
\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Friend

\_\_\_\_\_ Self-Referral

\_\_\_\_\_ Other: \_\_\_\_\_