



## Patient History Form

J. Francois Eid, M.D.

**Note: Confidential**

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

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

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

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**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 \_\_\_\_\_

**6. Past Treatment of Sexual Dysfunction**

- A. Were you ever treated with pills?                      Yes      No
- If yes, which ones?
  - 1. Viagra 25 50 100 mg                      Yes      No
  - Frequency \_\_\_\_\_      Result \_\_\_\_\_
  - Side effects \_\_\_\_\_
  - 2. Cialis 5 10 20 mg                      Yes      No
  - Frequency \_\_\_\_\_      Result \_\_\_\_\_
  - Side effects \_\_\_\_\_
  - 3. Levitra 5 10 20 mg                      Yes      No
  - Frequency \_\_\_\_\_      Result \_\_\_\_\_
  - Side effects \_\_\_\_\_

B. Were you treated with any of the following:

1. Urethral suppositories (Muse)? Yes No  
Frequency \_\_\_\_\_ Result \_\_\_\_\_  
Side effects \_\_\_\_\_

2. Penile Injections? Yes No  
Frequency \_\_\_\_\_ Result \_\_\_\_\_  
Side effects \_\_\_\_\_

3. External vacuum device? Yes No  
Frequency \_\_\_\_\_ Result \_\_\_\_\_  
Side effects \_\_\_\_\_

## Past Medical and Social History

**1. Do you have any medical illnesses or conditions?** No Yes Onset/Duration  
Circle any of the following that apply: 1. High blood pressure Date: \_\_\_\_\_  
2. High cholesterol levels Date: \_\_\_\_\_  
3. Heart disease Date: \_\_\_\_\_  
4. Diabetes Date: \_\_\_\_\_  
5. Prostate cancer Date: \_\_\_\_\_

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

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

Hernia repair: \_\_ Right \_\_ Left \_\_ Bilateral \_\_ Mesh \_\_ Without Mesh Date: \_\_\_\_\_

Cardiac Catheterization/Stent: \_\_\_\_\_ Date: \_\_\_\_\_  
Pacemaker Type: \_\_ St. Jude Date: \_\_\_\_\_ (Please provide us with your device ID)  
\_\_ Medtronic Date: \_\_\_\_\_ (Please provide us with your device ID)

Prostate Cancer Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
Robotic \_\_\_\_\_ Laparoscopic \_\_\_\_\_ Open \_\_\_\_\_

Kidney Transplant: \_\_ Right \_\_ Left Date: \_\_\_\_\_

Penile Implant: \_\_\_\_\_ Date: \_\_\_\_\_  
Rigid \_\_ Two Piece \_\_ Multi Component Inflatable \_\_  
AMS \_\_ Coloplast (Mentor) \_\_

Radiation Therapy: External Beam \_\_\_\_\_ Seeds \_\_\_\_\_ Date: \_\_\_\_\_

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

Bladder/Colon: \_\_\_\_\_ Date: \_\_\_\_\_

**4. Drug Allergies:** Yes No  
Please list: \_\_\_\_\_

**5. Medications:** Yes No

Please list all drugs, medications, eye drops, etc. including dose and frequency

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Do you take any blood thinners? Yes No  
If so, which one? Aspirin \_\_\_\_ Coumadin \_\_\_\_ Plavix \_\_\_\_ Pradaxa \_\_\_\_  
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: \_\_\_\_\_

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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

Last digital rectal examination: \_\_\_\_\_ Last PSA: \_\_\_\_\_

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?						
	None	1 time	2 times	3 times	4 times	5 or more times
TOTAL AUA Symptom Score = Sum of questions 1 -7 _____						

## Review of Symptoms

Do you now or have you had any problems related to the following symptoms?  
Circle Yes or No. **Please explain any "Yes" answers in the space provided.**

### Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Headaches	Yes	No
Weight loss	Yes	No
Other _____	Yes	No

### Eyes

Blurred vision	Yes	No
Double vision	Yes	No
Pain	Yes	No
Other _____	Yes	No

### Neurological

Tremors	Yes	No
Dizzy spells	Yes	No
Numbness	Yes	No
Other _____	Yes	No

### Integumentary

Skin rash	Yes	No
Boils	Yes	No
Persistent itch	Yes	No
Other _____	Yes	No

### Musculoskeletal

Joint pain	Yes	No
Neck pain	Yes	No
Back pain	Yes	No
Other _____	Yes	No

### Ear/ Nose/ Throat/ Mouth

Ear infection	Yes	No
Sore throat	Yes	No
Sinus problems	Yes	No
Other _____	Yes	No

### Genitourinary

Urine retention	Yes	No
Painful urination	Yes	No
Urinary frequency	Yes	No
Other _____	Yes	No

### Endocrine

Excessive thirst	Yes	No
Too hot/cold	Yes	No
Tired/sluggish	Yes	No
Other _____	Yes	No

### Gastrointestinal

Abdominal pain	Yes	No
Nausea/ vomiting	Yes	No
Indigestion	Yes	No
Other _____	Yes	No

### Cardiovascular

Chest pain	Yes	No
Varicose veins	Yes	No
High blood pressure	Yes	No
Other _____	Yes	No

### Respiratory

Wheezing	Yes	No
Frequent coughs	Yes	No
Shortness of breath	Yes	No
Other _____	Yes	No

### Hematological / Lymphatic

Swollen glands	Yes	No
Blood clot problems	Yes	No
Other _____	Yes	No

### Allergic / Immunologic

Hay fever	Yes	No
Drug allergies	Yes	No
Other _____	Yes	No

### Psychological

Are you generally satisfied with your life?	Yes	No
Do you feel seriously depressed?	Yes	No
Have you considered suicide?	Yes	No
Other _____		

## 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  
\_\_\_\_\_ AM NY  
\_\_\_\_\_ El Diario  
\_\_\_\_\_ Other

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

\_\_\_\_\_ Daily News  
\_\_\_\_\_ NY Post  
\_\_\_\_\_ Newsday  
\_\_\_\_\_ AM NY  
\_\_\_\_\_ El Diario  
\_\_\_\_\_ 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: \_\_\_\_\_