ISLAND UROLOGY
Mansel K. Kevwitch, M.D., F.A.C.S
David Rice, M.D.
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 – 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	

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

ISLAND HEALTH

ISLAND UROLOGY – ADULT HEALTH HISTORY FORM

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

11 System ROS

☐ **All Negative**

Patient Name: _____ **Phone:** _____

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ISLAND UROLOGY – ADULT HEALTH HISTORY FORM

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 #:** _____

ISLAND HEALTH

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

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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