THE BILLUPS CENTER
MEDICINE THAT MATTERS TO MEN

Initial Intake History Form

Patient's Name: _____ PCP's Name: _____

Date of Birth: _____ Age: _____ Race/Ethnicity: _____

Referring Physician Name: _____Specialty: _____

OVERVIEW

I would like to be evaluated and treated (if indicated) for the following conditions *(please check all that apply):*

- ❑ **Erectile Dysfunction**
  - Symptoms – Difficulty getting erection, Difficulty keeping (maintaining erection), Decreased firmness (rigidity)
- ❑ **Low Testosterone**
  - Symptoms – Decreased libido (sex drive), fatigue, mood changes (depression, irritability), erectile dysfunction, decrease muscle mass
- ❑ **Abnormal Penile Curvature (Peyronie's Disease)**
  - Symptoms – penile curvature that is bothersome to you or your partner
- ❑ **Urinary Symptoms**
  - Symptoms – frequency, urgency, waking up at night to urinate, weak urinary stream
- ❑ **Premature Ejaculation**
  - Symptoms – early or rapid ejaculation (coming) that is bothersome to you or your partner
- ❑ **Male Infertility**
  - Symptoms – inability to conceive after 6-12 months of unprotected intercourse
- ❑ **Well Man Visit**
  - No specific concerns

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

PAST MEDICAL HISTORY

Please check "YES" to all that apply to YOU:

	YES	NO		YES	NO
Diabetes			Low Testosterone		
Hypertension			Erectile Dysfunction		
High Cholesterol			Prostate Cancer		
Heart Attack			Surgery for Prostate Cancer		
Stroke			Radiation for Prostate Cancer		
Blocked Leg Arteries			Surgery for Benign Prostate Enlargement		
Blocked Neck Arteries			Anxiety		
Chest Pain			Depression		
Coronary Artery Disease			Hypothyroidism		
Congestive Heart Failure			Kidney Disease or Failure		
Irregular Heart Beat			Kidney Stones		
Blood Clot in Lung			History of Bypass Surgery		
Blood Clot in Leg Veins			Low Back Problems		
• Have you ever had a bone density evaluation (DEXA scan)?					
• Are you on androgen deprivation therapy for prostate cancer?					
• Have you had a rib, wrist, spine, hip, or other major fracture in adulthood?					
• Do you have a family history of hip fracture in either your mother or father?					
• Are you taking/have a history of taking steroids such as prednisone, dexamethasone, or hydrocortisone for a chronic medical condition?					
• Do you have a history of gastric bypass surgery, inflammatory bowel disease, or celiac disease?					
Additional Medical Problems					

CARDIOVASCULAR INTERVENTION HISTORY

Have you had any of the following **procedures**? Please indicate **Yes** or **No** and the date if applicable.

	Yes/Date	No		Yes/Date	No
Cardiac Cath			Ankle Brachial Index		
Carotid (neck) bypass			Penile Doppler Ultrasound		
Peripheral (leg) bypass			Carotid Ultrasound		
Artificial Pacer			Coronary Artery Bypass Surgery		
Automatic internal Defibrillator			Heart Valve Surgery		
Stress Test			Echocardiogram		
Coronary Calcium Score			Coronary CAT Scan Angiogram		

PAST SURGICAL & HOSPITALIZATION HISTORY

PAST SURGERIES AND DATES	PAST HOSPITALIZATION AND DATES
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

MEDICATIONS

Please list your current medications (attach paper if needed):

Medication	Dosage	Frequency (daily, twice a day, etc)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Do you have <u>ALLERGIES</u> to any medications? Yes or No

If **"yes"**, please list medications below and type of reaction (ie hives, swelling, shortness of breath):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

SOCIAL HISTORY

ALCOHOL

___Never

___Yes: (type, frequency, drinks per sitting) _____

SMOKING

___Never

___Former (specify years, packs per week, quit date) _____

___Current (specify years, packs per week) _____

EDUCATION:

__Less than High School Graduate __High School Graduate or Equivalent
__Some College __College Graduate __Post-Graduate/professional degree
__Other:_____

EMPLOYMENT:

__Employed (If so, where?)_____

__Unemployed __Homemaker __Retired __Disabled Medical __Other:_____

MARITAL STATUS:

__Single __Married __Divorced __Widowed __Separated __Living with someone __Common law marriage

CHILDREN: (Sex & Age; Health Status of Each)

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

Please Check all that apply

	Mother	Father	Sibling #1 Brother/Sister	Sibling #2 Brother/Sister	Sibling #3 Brother/Sister	Sibling #4 Brother/Sister
Alive/Age						
Deceased/Age						
Cause of Death						
Diabetes						
Hypertension						
Heart Disease						
Cancer/Type						
Thyroid Disease						
Peyronie's Disease						
Prostate cancer						
Other Medical Conditions:						

Grandparents: (alive or deceased; cause of death)

- **Maternal Grandmother _____**
- **Maternal Grandfather _____**
- **Paternal Grandmother _____**
- **Paternal Grandfather_____**

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

Review of Systems

Please circle any of the conditions that apply to you over the past year

Respiratory: asthma, chronic bronchitis, cough, shortness of breath with exertion, pneumonia, wheezing

Gastrointestinal: recurrent abdominal pain, indigestion/heartburn, colitis/enteritis

Neurological: tremors, dizzy spells, numbness, stroke

Hematologic/Lymphatic: blood clots, swollen glands, bleeding disorder, lymphoma, sickle cell disease or trait

Cardiovascular: chest pain, chest pressure/discomfort, pain in legs with walking, difficulty breathing, exertional chest pressure/discomfort, lower extremity swelling, near-syncope/near-fainting

Genitourinary: blood in urinary, urinary retention, painful/burning urination, UTI, kidney stones, prostatitis, prostate cancer, sexual transmitted diseases: syphilis, HIV/AIDS, herpes, gonorrhea, chlamydia

Endocrine: weight loss, excessive thirst, diabetes, thyroid disorder

Integumentary: skin rash, boils, persistent itch, skin cancer
Musculoskeletal: joint pain, neck pain, arthritis, back pain

Ear, Nose, Throat, Mouth: ear infection, sinus problems, hearing impairment

Eyes: blurred vision, double vision, pain

Allergic/Immunologic: anaphylaxis, hay fever, gout, HIV/AIDS

Psychological: depression, anxiety, alcohol use/abuse, drug use/abuse: marijuana, cocaine, heroine

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

International Prostate Symptom Score (IPSS)

Lower Urinary Tract Symptoms (LUTS) due to Benign Prostate Enlargement (BPE)

1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating? Circle one					
0 Not at all	1 Less than 1 time in 5	2 Less than half the time	3 About half the time	4 More than half the time	5 Almost always
2. Over the past month, how often have you had to urinate again less than two hours after you finished urinating? Circle one					
0 Not at all	1 Less than 1 time in 5	2 Less than half the time	3 About half the time	4 More than half the time	5 Almost always
3. Over the past month, how often have you found you stopped and started again several times when you urinated? Circle one					
0 Not at all	1 Less than 1 time in 5	2 Less than half the time	3 About half the time	4 More than half the time	5 Almost always
4. Over the past month, how difficult have you found it to postpone urination? Circle one					
0 Not at all	1 Less than 1 time in 5	2 Less than half the time	3 About half the time	4 More than half the time	5 Almost always
5. Over the past month, how often have you had a weak urinary stream? Circle one					
0 Not at all	1 Less than 1 time in 5	2 Less than half the time	3 About half the time	4 More than half the time	5 Almost always
6. Over the past month, how often have you had to push or strain to begin urination? Circle One					
0 Not at all	1 Less than 1 time in 5	2 Less than half the time	3 About half the time	4 More than half the time	5 Almost always
7. Over the past month, how many times did you typically get up to urinate from the time you went to bed until the time you got up in the morning? Circle one					
0 None	1 1 Time	2 2 Times	3 3 Times	4 4 Times	5 5 Times or more

8. If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?

Delighted	Pleased	Mostly Satisfied	Mixed (equally satisfied & dissatisfied)	Mostly Dissatisfied	Dissatisfied	Unhappy	Terrible

IPSS Score System: Total score for Questions 1 through 7 (Question 8 is a separate QOL score)		
0-7 Mildly symptomatic	8-19 Moderately symptomatic	20-35 Severely symptomatic

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

Sexual Health Inventory for Men (SHIM)

1. **Over the past 6 months: How do you rate your confidence that you could get and keep an erection?**

1	2	3	4	5
Very low	Low	Moderate	High	Very high

2. **Over the past 6 months: When you had erections with sexual stimulation, how often were your erections hard enough for penetration?**

1	2	3	4	5
Almost never/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/Always

3. **Over the past 6 months: During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?**

1	2	3	4	5
Almost never/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/Always

4. **Over the past 6 months: During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?**

1	2	3	4	5
Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult

5. **Over the past 6 months: When you attempted sexual intercourse, how often was it satisfactory to you?**

1	2	3	4	5
Almost never/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/Always

The SHIM score is the sum of the response to the 5 items				
22-25	**17-21**	**12-16**	**8-11**	**5-7**
No ED	Mild ED	Mild to Moderate ED	Moderate ED	Severe ED

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

VITALITY SYMPTOM SCORE (ADAM questionnaire, testosterone supplementation)

1. How would you rate your libido (sex drive)?

1 Terrible	2 Poor	3 Average	4 Good	5 Excellent

2. How would you rate your energy level?

1 Terrible	2 Poor	3 Average	4 Good	5 Excellent

3. How would you rate your strength/endurance?

1 Terrible	2 Poor	3 Average	4 Good	5 Excellent

4. How would you rate your "enjoyment of life"?

1 Terrible	2 Poor	3 Average	4 Good	5 Excellent

5. How would you rate your happiness level?

1 Terrible	2 Poor	3 Average	4 Good	5 Excellent

6. How strong are your erections?

1 Extremely Weak	2 Weak	3 Average	4 Strong	5 Extremely Strong

7. How would you rate your work performance over the past 4 weeks?

1 Terrible	2 Poor	3 Average	4 Good	5 Excellent

8. How often are you falling asleep after dinner?

1 Never	2 1-2 times/week	3 3-4 times/week	4 5-6 times/week	5 Every night

9. How would you rate your sports ability over the past 4 weeks?

1 Terrible	2 Poor	3 Average	4 Good	5 Excellent

10. How much height have you lost?

1 2" or more	2 1.5" to 1.9"	3 1" to 1.4"	4 0.5" to 0.9"	5 None to 0.4"

Scoring			
Score 10 -20: Severe Symptoms of Low Testosterone	**Score 21-30: Moderate Symptoms of Low Testosterone**	**Score 31-40: Mild Symptoms of Low Testosterone**	**Score 41-50: Minimal/No Symptoms of Low Testosterone**

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9): Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than one-half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Total:	**_____ +**	**_____ +**		**_____**

Interpretation

Total Score	Depression Severity
1—4	Minimal
5—9	Mild
10—14	Moderate
15—19	Moderately severe
20—27	Severe

SLEEP APNEA SCREENING

	YES	**NO**
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?		
Do you often feel TIRED, fatigued, or sleepy during daytime?		
Has anyone OBSERVED you stop breathing during your sleep?		
Do you have or are you being treated for high blood PRESSURE?		

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

PEYRONIE'S DISEASE (PENILE CURVATURE) QUESTIONNAIRE

(Only Complete This Section If you have Penile Curvature/Peyronie's Disease)

1. Approximate duration of penile curvature/Peyronie's Disease in YEARS: _____
   a. This problem started (circle one): **Gradually Suddenly**
   b. If suddenly, was it related to: **Surgery New Medication Life Event Penile Injury**

2. Are your erections bent? **YES NO**

3. What is the direction of the bend (up, down, left, right)? _____

4. How much is the penis bent with an erection (in degrees): _____

5. Do you experience pain in the penis with erection? **YES NO**

6. Have you noticed a lump inside your penis? **YES NO**

7. Has your penis gotten shorter since this problem started? **YES NO**

8. Does the penile curvature prevent sexual intercourse? **YES NO**

9. Does the bend cause pain to your partner? **YES NO**

10. Do you have a family history of PEYRONIE'S DISEASE? **YES NO**

11. Do you notice a circumferential narrowing or indentation on any part of your penile shaft? **YES NO**

12. Does anyone in your family have any scar tissue in their hands? **YES NO**

13. Is the rigidity of your erection satisfactory for sexual intercourse? **YES NO**

14. Do you recall injuring or forcibly bending your penis? **YES NO**

Patient's Name: _____ Patient's DOB: _____ Today's Date_____

Previous Evaluation and Treatment for Peyronie's Disease (Penile Curvature)

1. Have you tried Vitamin E? **YES** **NO**
   Did it work to your satisfaction? **YES** **NO**

2. Have you tried POTABA? **YES** **NO**
   Did it work to your satisfaction? **YES** **NO**

3. Have you tried pentoxifylline (Trental)? **YES** **NO**
   Did it work to your satisfaction? **YES** **NO**

4. Have you tried Arginine? **YES** **NO**
   Did it work to your satisfaction? **YES** **NO**

5. Have you received any Verapamil penile injections? **YES** **NO**
   Did the Verapamil injections help? **YES** **NO**

6. Have you received any Xiaflex (Collagenase) penile injections? **YES** **NO**
   Did the Xiaflex injection help? **YES** **NO**

7. Have you undergone penile straightening? **YES** **NO**
   Did it work initially? **YES** **NO**

8. Have you tried Viagra, Cialis or Levitra? **YES** **NO**
   Did it work to your satisfaction? **YES** **NO**

9. Have you tried any other treatment? **YES** **NO**
   *What was this treatment?*_____