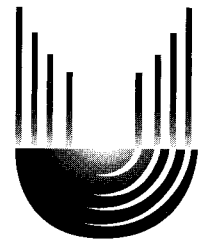


IF YOU'RE A MAN

Take these tests and find out about 2 common conditions

Erection difficulties are when a man can't get or keep an erection. This is also known as erectile dysfunction (ED). About 30 million men in the US have some degree of ED. Also common in men is benign prostatic hyperplasia (BPH). This is a urinary problem in men older than 50.

It may feel awkward to talk to your doctor. But you are not alone. Many men have talked to their doctors about these problems. So take these tests. And help your doctor find out if treatment is right for you.



Arkansas Urology

Could you benefit from treatment for BPH?

Please circle the answer that *best describes* your response to each of the following questions.

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
0	1	2	3	4	5

1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?

0	1	2	3	4	5
---	---	---	---	---	---

2. Frequency Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?

0	1	2	3	4	5
---	---	---	---	---	---

3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?

0	1	2	3	4	5
---	---	---	---	---	---

4. Urgency Over the past month, how often have you found it difficult to postpone urination?

0	1	2	3	4	5
---	---	---	---	---	---

5. Weak stream Over the past month, how often have you had a weak urinary stream?

0	1	2	3	4	5
---	---	---	---	---	---

6. Straining Over the past month, how often have you had push or strain to begin urination?

0	1	2	3	4	5
---	---	---	---	---	---

7. Nocturia Over the past month, how many times 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+
---	---	---	---	---	----

Score _____

Add the numbers from your answers to questions 1 through 7. The maximum possible score is 35. Remember: This information is not intended as a substitute for medical treatment.

Note: This test is used to measure the severity of your symptoms. It is not a diagnostic test. In other words, it will not tell you whether or not you have BPH. Talk to your doctor to determine if your symptoms are due to BPH.

Adapted from Barry MJ, et al. The American Urological Association symptom index for benign prostatic hyperplasia. *J Urol.* 1992; 148:1549-1557.

Could you benefit from treatment for ED?

Each question has several possible responses. Please circle the number of the response that *best describes* your own situation. Make sure that you select 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 to you?

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

Score _____

Add the numbers corresponding to questions 1 through 5. If your score is 21 or less, you may want to talk to your doctor.

Adapted from Rosen RC, et al. Development and evaluation of an abridged, 5-item version of the International Index of Erectile Function (IIEF-5) as a diagnostic tool for erectile dysfunction. *Int J Impot Res.* 1999; 11:319-326.

REVIEW OF SYSTEMS (MALE)

Do you now or have you had any problems related to the following symptoms? Darken the circle Y (yes) when the symptom is present or N (no) when not present. *Please mark yes or no for each choice.*

<p>GENITOURINARY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Burning with urination</p> <p><input type="radio"/> <input type="radio"/> Blood in urine</p> <p><input type="radio"/> <input type="radio"/> Leakage of urine</p> <p><input type="radio"/> <input type="radio"/> Nighttime voiding: ____ times a night</p> <p><input type="radio"/> <input type="radio"/> Erectile dysfunction</p> <p><input type="radio"/> <input type="radio"/> Flank pain <input type="radio"/> Left side? <input type="radio"/> Right side?</p> <p><input type="radio"/> <input type="radio"/> Scrotal (sack) Pain</p> <p style="padding-left: 100px;"><input type="radio"/> Left side? <input type="radio"/> Right side?</p>	<p>INTEGUMENTARY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Skin Rash</p> <p><input type="radio"/> <input type="radio"/> Boils</p> <p><input type="radio"/> <input type="radio"/> Varicose Veins</p> <p><input type="radio"/> <input type="radio"/> Enlarged breast</p> <p><input type="radio"/> <input type="radio"/> Painful breast</p>
<p>CONSTITUTIONAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Fever</p> <p><input type="radio"/> <input type="radio"/> Chills</p> <p><input type="radio"/> <input type="radio"/> Headaches</p> <p><input type="radio"/> <input type="radio"/> Unexplained weight loss</p>	<p>NEUROLOGICAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Tremors</p> <p><input type="radio"/> <input type="radio"/> Dizzy Spells</p> <p><input type="radio"/> <input type="radio"/> Numbness/Tingling</p>
<p>EYES</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Impaired Vision</p> <p><input type="radio"/> <input type="radio"/> Pain in eyes</p>	<p>PSYCHIATRIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Do You Have a Depressed Mood?</p> <p><input type="radio"/> <input type="radio"/> Are You Overly Anxious?</p>
<p>EARS, NOSE, MOUTH, THROAT</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Ear Infection</p> <p><input type="radio"/> <input type="radio"/> Sore Throat</p> <p><input type="radio"/> <input type="radio"/> Sinus Problems</p>	<p>ENDOCRINE</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Excessive Thirst</p> <p><input type="radio"/> <input type="radio"/> Too Hot / Cold</p> <p><input type="radio"/> <input type="radio"/> Tired / Sluggish</p> <p><input type="radio"/> <input type="radio"/> Diminished Sexual Drive</p> <p><input type="radio"/> <input type="radio"/> Decreased Muscle Size or Strength</p> <p><input type="radio"/> <input type="radio"/> Problems With Erection</p>
<p>CARDIOVASCULAR</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Chest Pain</p> <p><input type="radio"/> <input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> <input type="radio"/> Swelling in Extremities</p>	<p>HEMATOLOGIC / LYMPHATIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Swollen Glands</p> <p><input type="radio"/> <input type="radio"/> Blood Clotting Problems</p>
<p>RESPIRATORY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Wheezing</p> <p><input type="radio"/> <input type="radio"/> Frequent Coughing</p> <p><input type="radio"/> <input type="radio"/> Shortness of Breath</p>	<p>ALLERGIC / IMMUNOLOGIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Hay Fever</p> <p><input type="radio"/> <input type="radio"/> Drug Allergies</p>
<p>GASTROINTESTINAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Abdominal Pain</p> <p><input type="radio"/> <input type="radio"/> Nausea / Vomiting</p> <p><input type="radio"/> <input type="radio"/> Diarrhea or Loose Stool</p> <p><input type="radio"/> <input type="radio"/> Blood in Stool</p>	<p>Physician Use Only: (Comments / Notes)</p> <hr/> <hr/> <hr/>
<p>MUSCULOSKELETAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Chronic Neck Pain</p> <p><input type="radio"/> <input type="radio"/> Chronic Back Pain</p> <p><input type="radio"/> <input type="radio"/> Pain that Radiates Down Leg</p> <p style="padding-left: 20px;">Which side? <input type="radio"/> Right? <input type="radio"/> Left? <input type="radio"/> Both?</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p>	

Social Security Number

____/____/____

PAST MEDICAL HISTORY

Section 1

Do you now or have you had the following illnesses? Fill in the circle (Yes or No) and please Give the approximate date when requested. Please mark yes or no for each choice.

- Y N
0 0 Urinary tract problem -----> 1) What type? _____ When? _____
0 0 Bleeding -----> 2) What type? _____ When? _____
0 0 Cancer -----> 1) What type? _____ When? _____
0 0 Hepatitis -----> 2) What type? _____ When? _____
0 0 Stroke -----> What type? _____ When? _____
0 0 Heart Attack (MI) -----> When? _____
0 0 Heart Disease
0 0 Heart Failure
0 0 Irregular Heartbeat
0 0 High Blood Pressure
0 0 Diabetes
0 0 HIV
0 0 Emphysema
0 0 Pneumonia -----> When? _____
0 0 Asthma
0 0 Anemia
0 0 Seizure
0 0 Kidney Stones
0 0 Kidney Disease -----> What type? _____
0 0 Gout
0 0 Glaucoma
0 0 Thyroid Disease
0 0 Arthritis
0 0 Ulcer
0 0 Blood Disorder -----> What type? _____
0 0 Sickle Cell
0 0 Mental Illness / Condition -----> What type? _____
0 0 Neurological Condition -----> What type? _____
0 0 Gallstones
0 0 Gastroesophageal reflux ("GERD")
0 0 History of trauma / injury to the penis, testicles, or in this area. If "yes", what? _____

Other Serious Illnesses, Injuries or Treatments: _____

PAST SURGICAL HISTORY: Fill in the appropriate circle and give date.

- PROSTATE SURGERY Y N
0 0
If "yes", what type? When? _____
0 0 Transurethral (through scope, no scar)
0 0 Abdominal (scar lower abdomen)

VASECTOMY 0 0 When? _____

PAST SURGICAL HISTORY (MALE) – PFSH cont.

SECTION 1 – cont

KIDNEY STONE SURGERY Y N
O O If "yes", how many total times?
If "yes", check all that apply:
O O Stone Extraction with Scope When?
O O ESWL (Shockwave Lithotripsy – no scope) When?
O O Stent Only When?
O O Open Surgical Removal (big scar) When?
O O Percutaneous Removal (small scar in flank/side) When?
Other

KIDNEY SURGERY Y N
O O Nephrectomy When? Why?
O Right
O Left
O O Stone Surgery
O O Other Kidney Surgery What type?

HERNIA Y N
O O When?
If "yes", what type?
O Right inguinal / groin
O Left inguinal / groin
O Incisional (in an old scar)
O Umbilical (belly button)
O Other What type?

GALLBLADDER SURGERY Y N
O O When?
If "yes", what type?
O Laparoscopic Surgery (small scars)
O Open (big scar)

APPENDIX SURGERY Y N
O O When?
If "yes", what type?
O Laparoscopic Surgery (small scars)
O Open (big scar)

HEART SURGERY Y N
O O When?
If "yes", what type?
O Bypass
O Heart Valve
O Angioplasty / Stent
O Other What Type?

BACK SURGERY Y N
O O When?

NECK SURGERY Y N
O O When?

VASCULAR SURGERY Y N
O O When?
(Blood Vessel) What kind?

Other – Please List Type of Surgery With Date:

ALLERGIES:

Y N
O O

Please list medication to which you are allergic:

Type of Reaction(s):

Nausea Rash Swelling Breathing Problems Other (Describe)

Social Security Number

____/____/____

MEDICATIONS – Do you take any medications? (Include aspirin and vitamin supplements)

Yes No

If yes, please list:

Medication

Dosage or Amount

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Note: If you need more space, please ask for an additional medication sheet.

Do you take?

Y N

Blood Thinner? (e.g. Aspirin, Coumadin, Plavix) What Type(s)? _____

ALLERGIES:

Y N

Please list medication to which you are allergic:

Type of Reaction(s):

Nausea Rash Swelling Breathing Problems Other (Describe)

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Note: If you need to list more allergies, please ask for an additional allergy sheet.

Y N

Are you allergic to x-ray dye? What type of reaction? _____

Are you allergic to iodine or seafood? What type of reaction? _____

Are you allergic to latex? What type of reaction? _____

SECTION II

FAMILY HISTORY:

If the answer to any of these questions is yes, please tell which relative.

Do you have a family history of

Y N

Prostate cancer? Relative? _____

Cancer of the kidneys, ureters, bladder, penis, testicles or any other part of the urinary tract? Relative? _____ Type? _____

Urinary tract infections? Relative? _____

Kidney stones? Relative? _____ Type? _____

Kidney disease? Relative? _____

Hematuria/blood in urine? Relative? _____

PATIENT REGISTRATION

ARKANSAS UROLOGY, P.A.

ACCT.# _____

CLINIC LOCATION _____

Date _____ Appt. Time _____

Pharmacy _____

Today's appt. is with Dr. _____

Pharmacy phone _____

PATIENT INFORMATION

Name _____ Last _____ First _____ M.I. _____ Sex _____ Age _____ Date of Birth _____

Mailing Address _____ Social Security _____

Physical Address _____ Patient Place of Employment _____

Home Phone _____ Work Phone _____ Spouse/Parent Name _____

Pager # _____ Cell Phone _____ Spouse/Parent Work # _____

E-Mail _____

Name and phone # next of kin not living with you _____

PERSON RESPONSIBLE FOR BILL

Name _____ Last _____ First _____ M.I. _____ Home Phone _____ Work Phone _____

Address _____ Relation to Patient _____

OTHER INFORMATION

Who referred you to this clinic? Doctor _____ Specialty _____ City _____

Family Member Friend Name _____ Yellow Pages Advertisement Referral Service

Have you ever seen any of our doctors as a patient before? _____ In Office _____ In Hosp. _____

Allergies _____ Latex Allergy: Yes No

Reason for Visit _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Phone () _____

Address to mail claims _____

Policy # _____ Group # _____ Program # _____

Policyholder Name _____ Address _____

Policyholder Phone _____ Policyholder Birthdate _____ Sex _____

Policyholder Employer/School _____

Policyholder Relationship to Patient _____ Policyholder SSN _____

Does your primary insurance require Pre-Authorization/Pre-certification? Yes No

Are referrals from primary care physician required? Yes No Primary Physician's Name _____

Secondary Insurance Carrier _____ Phone () _____

Address to mail claims _____

Policy # _____ Group # _____ Program # _____

Policyholder Name _____ Address _____

Policyholder Phone _____ Policyholder Birthdate _____ Sex _____

Policyholder Employer/School _____

Policyholder Relationship to Patient _____ Policyholder SSN _____

Is this policy: A. Medicare Supplemental Policy or B. Employer Sponsored Do you have papers from attorney / Work. Comp? Yes No

MEDICAL RELEASE INFORMATION

I authorize the release of any medical information necessary to process insurance claims for services and/or supplies provided by Arkansas Urology, P.A.

PAYMENT OF BENEFITS

I authorize payment of medical benefits to Arkansas Urology for services and/or supplies provided by them.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I Understand and agree that, (regardless status), I am ultimately responsible for the balance on my account for any professional services rendered.

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

X _____

Date _____

ARKANSAS UROLOGY, P.A.
3401 Springhill Drive · Suite 345
North Little Rock, AR 72117

ACKNOWLEDGEMENT

By my signature below, I acknowledge that I have received a copy of the Arkansas Urology, P.A.'s *Notice of Privacy Practices*.

Patient Signature

Arkansas Urology Pre-Procedure Questionnaire

Patient's Name: _____ DOB: _____
Date: _____ DR: _____

1) Do you see a Heart Doctor? Yes___ No___
If yes, for what condition _____
Please list physicians name and address _____

2) Do you see a Lung Doctor? Yes___ No___
If yes, for what condition _____
Please list physicians name and address _____

3) When was the last time you saw your doctor for these conditions?

4) Do you have any of the following conditions and when did it occur?

A) Heart Attack	Yes___	No___	When_____
B) Bypass Surgery	Yes___	No___	When_____
C) Pacemaker	Yes___	No___	When_____
D) Defibrillator	Yes___	No___	When_____
E) Heart or Leg Stent	Yes___	No___	When_____
F) Heart Murmur	Yes___	No___	When_____
G) Valve Replacement	Yes___	No___	When_____
H) Lung Surgery	Yes___	No___	When_____

5) Do you use Oxygen? Yes___ No___

6) Do you have Sleep Apnea and/or use a C-PAP? Yes___ No___

7) Do you take Coumadin (Warfarin), Plavix, Platel, Aspirin(including Ibuprophen), Arthritis Medicine, Vitamin E, or any other medicines that might thin your blood?
NO___ If YES, list them here_____

The above information has been provided to the best of my knowledge to
Arkansas Urology, P.A.

Sign: _____ Date: _____

Arkansas Urology Update Form

Patient Name: _____ Date of Birth: _____

Address: _____

Doctor Sign Off

Phone: _____ Work Phone: _____

Cell Phone: _____

Primary Insurance Company: _____

ID#: _____ Group#: _____

Secondary Insurance Company: _____

ID#: _____ Group#: _____

Pharmacy name & phone: _____

Referring DR: _____ PCP: _____

Medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Conditions:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical History:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: _____