Maui Medical Group, Inc.
Health Care Excellence For Maui Since 1961

Soren Carlsen, MD - Urologist

MEDICAL HISTORY

Patient Name_____ Age_____ Today's Date_____
Marital Status_____ How did you hear about us (physician, friend, ad)?_____
CURRENT OCCUPATION (please also state if retired)_____
Referring Physician_____ Primary Care Doctor _____

HISTORY OF PRESENT ILLNESS

REASON for today's visit _____
LOCATION of the problem _____

On a scale of 1-10 (10 being the most severe) circle the number that best describes the problem.
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other: _____

Does anything make the problem better or worse?
Moving around Standing up Lying on my side
Other: _____

How long does the problem last?
___Seconds ___Minutes ___Hours ___Always there

Describe the problem Constant or Variable?
Dull, Sharp or both, Very sharp then leaves
Other: _____

Is anything else occurring at the same time?
YES NO If yes, please explain_____

Does the problem interfere with your normal functions?
YES NO If yes, please explain_____

Would you like to discuss erectile function?
YES NO

Would you like to discuss urine incontinence?
YES NO

PAST MEDICAL & SOCIAL HISTORY

CHECK ALL OF THE FOLLOWING THAT APPLY

PERSONAL HISTORY OF:

__ALCOHOLISM	__DIABETES	__HEPATITIS	__KIDNEY STONES
__ARTHRITIS	__GOUT	__HERNIA : type_____	__MULTIPLE SCLEROSIS
__ASTHMA	__HEART ATTACK	__HIGH BLOOD PRESSURE	__PARKINSON'S DISEASE
__CANCER(ANY)_____	__HEART MURMUR	__HIGH CHOLESTEROL	__PROSTATE CANCER
__RECURRENT BLADDER/KIDNEY INFECTIONS		OTHER:_____	

PAST SURGICAL HISTORY OF: (*please specify if any are positive)*

__PROSTATE_____	__HYSTERECTOMY_____	__BLADDER_____	__URETHRA _____
__CIRCUMCISION_____	__VASECTOMY_____	__GALL BLADDER	__HEART _____
__HERNIA_____	__INTESTINES_____	__BACK/NECK_____	__KIDNEY _____
__KIDNEY STONE_____		__HIP/KNEE REPLACEMENT _____	

__CANCER(specify) _____
OTHER: _____

FAMILY HISTORY OF:

__PROSTATE CANCER __KIDNEY STONES OTHER: _____

SOCIAL HISTORY OF:

Do you now or did you ever smoke? Y N
How many packs/day____ Years smoked _____
When quit? _____
Do you drink alcoholic beverages? Y N
Type_____ Amount_____

Have you ever had a blood transfusion? Y N
Do you take Aspirin or blood thinner? Y N
Are you on a special diet? Y N
Are you sexually active? Y N

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Do you have allergies to any medications? Y N

Please list: _____

Are you taking any prescription or non-prescription medications? Y N

Please list medications and dosages:

Medication Name	Dose
_____	_____
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS

Do you now or have you had any recent problems related to the following systems? Circle **Yes** or **No**.

Please explain any Yes answers in space provided.

Constitutional Symptoms
Fever Y N
Other/Comments _____

Eyes
Recent Vision Changes Y N
Other/Comments _____

Cardiovascular
Chest Pain Y N
Other/Comments _____

Respiratory
Cough Y N
Shortness of breath Y N
Other/Comments _____

Gastrointestinal
Abdominal pain Y N
Nausea/vomiting Y N
Other/Comments _____

Genitourinary
Urine retention (can't void) Y N
Urine incontinence (leakage) Y N
Urinary frequency Y N
Painful urination Y N
Erection difficulties Y N
Other/Comments _____

Musculoskeletal
Back Pain Y N
Other/Comments _____

Integumentary
Skin rash/lesions Y N
Other/Comments _____

Neurological
Headaches Y N
Lightheadedness Y N
Other/Comments _____

Psychiatric
Anxiety Y N
Other/Comments _____

Hematologic/Lymphatic
History of Blood Clots
(DVT or PE) Y N
Other/Comments _____

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(AUA-SS) SYMPTOM INDEX FOR BPH

Patient Name: _____ Date: _____

Please fill out this short questionnaire to help us find out more about any urinary problems you might have.
For each question, circle the number under the column that best describes your situation.

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. INCOMPLETE EMPTYING: 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. FREQUENCY: 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. INTERMITTENCY: 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. URGE TO URINATE: 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 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. URINATING AT NIGHT: 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

Quality of Life Bother Score

	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

From the American Urological Association (AUA) Symptom Index for BPH - Appendix A
with the International Prostate Symptom Score (IPSS)

{Turn Over} ----> >

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Urine Leakage (Incontinence)

	No Leakage	Mild (A Few drops a day, no pad use)	Mild (More than a few drops a day, 1-2 pad/day)	Moderate (3 or more pads per day)	Severe Leakage Problems
Circle One	**0**	**1**	**2**	**3**	**4**

Sexual Health Inventory For Men

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.

Current Status: _____

	Very Low	Low	Moderate	High	Very High
1. How do you rate your **confidence** that you could achieve and keep an erection?	1	2	3	4	5

	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
2. When you had erections with sexual stimulation, **how often** were your erections had enough for penetration (entering your partner)?	0	1	2	3	4	5

	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
3. During sexual intercourse, **how often** were you able to maintain your erection after you had penetrated (entered) your partner?	0	1	2	3	4	5

	Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
4. During sexual intercourse, **how difficult** was it to maintain your erection to completion of intercourse?	0	1	2	3	4	5

	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
5. When you attempted sexual intercourse, **how often** was it satisfactory to you?	0	1	2	3	4	5

SHIM Total Score = _____ (Add the numbers corresponding to questions 1-5)

SHIM total score: 22-25 [No ED] ; 17-21 [Mild] ; 12-16 [Mild to Moderate] ; 8-11 [Moderate] ; 1-7 [Severe ED]