Office of Dr. Ash K. Tewari, MD
Chairman Dept. of Urology
Icahn School of Medicine at Mount Sinai
Ph: (212) 241-9955

Date: ______________________

Name: ____ DOB: ___________________ Age: ________

Address: ____

Email: ______________________________________ City: __________________ State: ______ Zip: _______

Home #: _______________________ Work #: _______________________ Cell #: _______________________

Emergency Contact (Relationship) and Number: ____

Reason for Visit: ____

Referring MD:

Name: ____

Address: _______________________________________

____

Phone #: _______________________________________

Fax #: ____

Would you like this MD to be notified? Yes No

Primary Care Physician:

Check if PMD is the Referring MD

Name: ____

Address: _______________________________________

____

Phone #: _______________________________________

Fax #: ____

Would you like this MD to be notified? Yes No

Urologist:

Check if Urologist is the Referring MD

Name: ____

Address: _______________________________________

____

Phone #: _______________________________________

Fax #: ____

Would you like this MD to be notified? Yes No

Cardiologist:

Check if Cardiologist is the Referring MD

Check if Cardiologist is the Primary Care MD

Name: ____

Address: _______________________________________

____

Phone #: _______________________________________

Fax #: ____

Would you like this MD to be notified? Yes No

Is there anyone else who you would like for us to notify of your medical status? Please list them here:

Name:

Address:

Phone #:

Fax #:

Name:

Address:

Phone #:

Fax #:

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Date: ______________________ Reason for Today's Visit: ______________________

Name: ____ DOB: ___________________ Age: ________

Past Medical History

Hypertension	Bleeding Disorder	Blood Clots	Thyroid Disorder	Stroke / Heart Disease
Heart Murmur	Diabetes	Seizure Disorder	Hemorrhoids / IBS	Enlarged Prostate
Anemia	Kidney Disease	High Cholesterol	Hernia	Sexual Dysfunction

Other: ____

Surgical History

___

Medication Name and Dosage (including supplements)

___

Allergic to any meds? No Yes

If yes, list medication & reaction: ____

Social History

Occupation: _________________________________

Marital Status: _______________________________

Children: No Yes Number: ________________

Smoke: No Yes (list # packs and years) _____________

Alcohol: No Yes (list drinks per week) _______________

Caffeine: No Yes (list # per day) __________________

Family History	Yes	No	Family Member
Prostate Cancer			____________________
Colon Cancer			____________________
Bladder Cancer			____________________
Heart Disease			____________________
Other: ____________			____________________

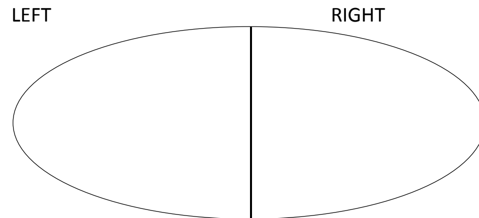
Review of Systems

Constitutional		
Significant Changes in Weight	Yes	No
Fevers and Chills	Yes	No
Fatigue	Yes	No
Persistent Headaches	Yes	No
Visual Problems	Yes	No
Cardiovascular		
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Palpitations	Yes	No
Respiratory		
Cough / Wheezing	Yes	No
Gastrointestinal		
Nausea and Vomiting	Yes	No
Diarrhea or Constipation	Yes	No
Genitourinary		
Burning on Urination	Yes	No
Blood in Urine	Yes	No
Incontinence of Urine	Yes	No
Musculoskeletal		
Muscle Weakness	Yes	No
Skin		
Skin rash or Lesion	Yes	No
Neurological		
Seizures	Yes	No
Numbness or Tingling	Yes	No
Psychiatric		
Depression / Anxiety	Yes	No
Hematology		
Easy Bruising	Yes	No
Unusual Bleeding	Yes	No

FOR OFFICE USE ONLY

Urologist: ______________________________

Biopsy Date: ____________________________



IIEF:

IPSS:

PSA: ___________ | Prostate Volume: ____________________

DRE: ___________ | Number of Total Past Biopsies: __________

Height: _________ | Weight: _________ | BMI: ___________

Imaging:

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IIEF

NAME ______________________________

DATE OF BIRTH AGE

ADDRESS

____

Patient Questionnaire

TELEPHONE ______________________________

These questions ask about the effects that your erection problems have had on your sex life over the last four weeks. Please try to answer the questions as honestly and as clearly as you are able. Your answers will help your doctor to choose the most effective treatment suited to your condition. In answering the questions, the following definitions apply:

- **sexual activity** includes intercourse, caressing, foreplay, & masturbation.
- **sexual intercourse** is defined as sexual penetration of your partner.
- **sexual stimulation** includes situation such as foreplay, erotic pictures, etc.
- **ejaculation** is the ejection of semen from the penis (or the feeling of this).
- **orgasm** is the fulfillment or climax following sexual stimulation or intercourse.

Over the past 4 weeks:

Q1 How often were you able to get an erection during sexual activity?

0 No sexual activity
1 Almost never or never
2 A few times (less than half of the time)
3 Sometime (about half of the time)
4 Most times (more than half of the time)
5 Almost always or always

Q2 When you had erections with sexual stimulation, how often were your erections hard enough for penetration?

0 No sexual activity
1 Almost never or never
2 A few times (less than half of the time)
3 Sometime (about half of the time)
4 Most times (more than half of the time)
5 Almost always or always

Q3 When you attempted intercourse, how often were you able to penetrate (enter) your partner?

0 Did not attempt intercourse
1 Almost never or never
2 A few times (less than half of the time)
3 Sometime (about half of the time)
4 Most times (more than half of the time)
5 Almost always or always

Q4 During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

0 Did not attempt intercourse
1 Almost never or never
2 A few times (less than half of the time)
3 Sometime (about half of the time)
4 Most times (more than half of the time)
5 Almost always or always

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Name DOB

	Question	Responses
Q5	During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	0 Did not attempt intercourse 1 Extremely difficult 2 Very difficult 3 Difficult 4 Slightly difficult 5 Not difficult
Q6	How many times have you attempted sexual intercourse?	0 No attempts 1 One or two attempts 2 Three or four attempts 3 Five or six attempts 4 Seven to ten attempts 5 Eleven or more attempts
Q7	When you attempted sexual intercourse, how often was it satisfactory for you?	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q8	How much have you enjoyed sexual intercourse?	0 No intercourse 1 No enjoyment at all 2 Not very enjoyable 3 Fairly enjoyable 4 Highly enjoyable 5 Very highly enjoyable
Q9	When you had sexual stimulation or intercourse, how often did you ejaculate?	0 No sexual stimulation or intercourse 1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q10	When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?	1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q11	How often have you felt sexual desire?	1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q12	How would you rate your level of sexual desire?	1 Very low or none at all 2 Low 3 Moderate 4 High 5 Very high
Q13	How satisfied have you been with your overall sex life?	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied
Q14	How satisfied have you been with your sexual relationship with your partner?	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied
Q15	How do you rate your confidence that you could get and keep an erection?	1 Very low or none at all 2 Low 3 Moderate 4 High 5 Very high

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INTERNATIONAL PROSTATE SYMPTOM SCORE (IPSS)

NAME ____ DATE ____________________________

The questionnaire below was developed by the American Urological Association (AUA) to help men evaluate the severity of their symptoms from benign hyperplasia (BHP). This self-administered test can help determine which treatment is needed, if any. Symptoms are classified as mild (1 to 7), moderate (8 to 19), or severe (20 to 35). Generally, no treatment is needed if symptoms are mild; moderate symptoms usually call for some form of treatment; and severe symptoms indicate that surgery is most likely to be effective.

Q1 Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

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

Q2 Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

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

Q3 Over the past month, how often have you found you stopped and started again several times when you urinated?

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

Q4 Over the past month, how often have you found it difficult to postpone urination?

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

Q5 Over the past month, how often have you had a weak urinary stream?

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

Q6 Over the past month, how often have you had to push or strain to begin urination?

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

Q7 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 None
1 One time
2 Two times
3 Three times
4 Four times
5 Five times

TOTAL SCORE

Q8 How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?

0 Delighted
1 Pleased
2 Mostly Satisfied
3 Mixed
4 Mostly Dissatisfied
5 Unhappy
6 Terrible

Source: American Urological Association

We have partnered with Medivizor to help provide our patients personalized health information and updates, specifically for your medical situation. If you'd like to receive invitation to use this unique and new service (for free and completely HIPAA compliant and private), please fill in this form and return it filled in:

Personalized Health Information

Medivizor is a new, unique, and free health information service.

The service is already helping thousands of patients and caregivers cope with serious or chronic illness by providing them health information and subsequent updates tailored for each patient's particular situation.

Such information includes information about the medical condition, its treatment options, cutting-edge research, matching clinical trials, and more. All the information is based on the most credible sources and summarized briefly in high-school level English making it easy to understand and act upon.

Fill in your email address and the medical condition(s) of your interest to get invited by email. If your condition is not listed below, you may add it under "other" and Medivizor will notify you once it starts supporting it.

Your email address: ____________________________________

Select your condition(s):

Benign prostatic hyperplasia
Breast cancer
Colorectal cancer
Diabetes
Erectile dysfunction
Heart attack / coronary artery disease
Hypertension
Infertility
Kidney stones
Lung cancer
Melanoma
Prostate cancer
Rheumatoid arthritis
Stroke
Urinary incontinence
Urinary tract infection

Other: _____________________________

Check this box to receive your private and free Medivizor invitation.

To learn more: **www.medivizor.com**

For any help, please contact care@medivizor.com. Thanks!

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Email Consent Form

This consent authorizes Dr. Ash Tewari and his administrative/digital teams to communicate with you using open internet email channels.

This consent allows Dr. Ash Tewari and his administrative/digital teams to communicate with you using any email address that you provide.

You authorize Dr. Ash Tewari and his administrative/digital teams to send you emails regarding non-patient health information/updates. *Email frequency will be no more than once a month. Emails will not be used for solicitation of funds.*

You understand that you can "opt out" of these emails by replying, as such, to one of the emails you receive.

Patient Name: ________________________

Patient Email Address: ____________________________

Patient Signature: _____________________________

Date: _________________________________