Dr. Steven A. Kaplan
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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

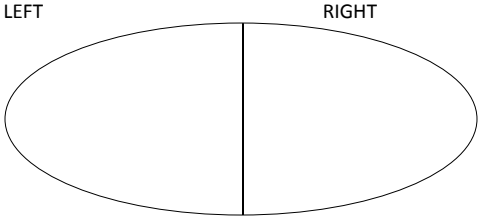
Constitutional		
	Significant Changes in Weight	Yes ○ ○ No
	Fevers and Chills	Yes ○ ○ No
	Fatigue	Yes ○ ○ No
	Persistent Headaches	Yes ○ ○ No
	Visual Problems	Yes ○ ○ No
Cardiovascular		
	Shortness of Breath	Yes ○ ○ No
	Chest Pain	Yes ○ ○ No
	Palpitations	Yes ○ ○ No
Respiratory		
	Cough / Wheezing	Yes ○ ○ 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: _____

LEFT RIGHT



IIEF: 6

IPSS: 0

PSA: _____ | Prostate Volume: _____

DRE: _____ | Number of Total Past Biopsies: _____

Height: _____ | Weight: _____ | BMI: _____

Imaging:

International Prostate Symptom Score (I-PSS)

Patient Name: _____ Date of birth: _____ Date completed _____

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were 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**

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 for 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

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**

Mount Sinai

Medivizor

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
- ☐ Hodgkin's Lymphoma
- ☐ Hypertension
- ☐ Infertility
- ☐ Kidney stones
- ☐ Infertility
- ☐ Other: _____
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Melanoma
- ☐ Multiple Myeloma
- ☐ Non-Hodgkin Lymphoma
- ☐ Prostate cancer
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Urinary incontinence
- ☐ Urinary tract infection

By signing below, you agree to receive a free and private email invitation to Medivizor:

Signature: _____

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

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