

SPECIFIC CONSENT FOR GENITAL OR PELVIC EXAMINATION

I, specifically consent, to have a genital examination performed on me if my urology provider so recommends. For males, this consent includes an examination of the external genitals and the prostate gland; for females, this consent includes a pelvic examination: the external genital and the internal genitalia (vagina, cervix, uterus, fallopian tubes, ovaries, and rectum).

Signature of Patient

Date

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative: _____

Date: _____

International Prostate Symptom Score (IPSS)

Patient Name: _____ **Date of Birth:** _____ **Age:** _____ **Today's Date:** _____

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying- How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency- How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency- How often you have found you stopped and started again several times while urinating?	0	1	2	3	4	5
Urgency- How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream- How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining- How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping- 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
Add Symptom Scores:						

Total International Prostate Symptom Score: _____

1-7 mild symptoms

8-19 moderate symptoms

20-35 severe symptoms

Regardless of the score, if your symptoms are bothersome, you should notify your doctor.

Quality of Life (QoL)	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Unhappy	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

Would you be interested in treatment options?	Yes	No
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SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: _____

TODAY'S DATE: _____

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

PLEASE FILL OUT THE FOLLOWING INFORMATION TO HELP US BETTER ASSIST YOUR NEEDS.

Patient Name: _____

Date of Birth: _____

Which symptoms best describe you? (Please check all that apply)

- frequent urination (day, night, or both)
- sudden or strong urge to urinate
- unable to empty bladder fully
- leaking with sneezing, coughing, or exercising
- leaking with urge or no warning (unable to make it to the restroom in time)
- bladder or pelvic pain
- none of the above (if checked, you are finished with this questionnaire)

How long have been experiencing these symptoms? _____

Have you tried any medications to help with the symptoms? YES NO

Circle all medications you have tried:

Detrol LA	Sanctura	DDAVP
Oxytrol Patch	Elavil	Ditropan XL
Enablex	Myrbetriq	Flomax
Vesicare	Elmiron	Cardura
DDAVP	Other:	

Have these medications helped? (Circle best answer)

No Relief

Total

Relief										
1	2	3	4	5	6	7	8	9	10	

Are you still taking these medications? YES NO

If not, why did you stop? did not help side effects too expensive

What is your level of frustration with your bladder symptoms? (Circle best answer)

Not Frustrated										Very Frustrated
1	2	3	4	5	6	7	8	9	10	

Do you currently have problems with bowel function? YES NO

If yes, please describe? constipation diarrhea bowel incontinence Other

Would you be interested in treatment options for your bladder symptoms other than medications? YES NO