Radiotherapy Clinics of Georgia
A Partner In The US Oncology Network

Radiotherapy Clinics of Georgia

Patient Initial History (This information is completely confidential.)

Patient ID Label

Patient Name: _____Date of birth: ___/___/_____ Age: _____ Today's Date: ___/___/_____

Referring M.D.
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

Primary M.D.
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

PAST MEDICAL HISTORY (Have you ever had any of the following?)

Prior Cancers – type	Yes	No	Kidney Failure	Yes	No
Angina	Yes	No	Kidney Stones	Yes	No
Heart attacks	Yes	No	Cystitis or Bladder Infections	Yes	No
Heart Failure	Yes	No	Prostatitis (men only)	Yes	No
Irregular Heart Beat	Yes	No	***Have you had more than 2 episodes within 3 years?***	Yes	No
Heart murmur	Yes	No	TURP (men only)	Yes	No
Arthritis	Yes	No	***If Yes, date of TURP*** ___/___/_____		
High Blood Pressure	Yes	No	Other Urological operations/procedures	Yes	No
If Yes, year of onset_____			***If Yes, please list in "surgeries" section below***		
Stroke or paralysis	Yes	No	Lupus	Yes	No
Asthma	Yes	No	Scleroderma	Yes	No
Anemia	Yes	No	Other Collagen Vascular Disease	Yes	No
Chronic Bronchitis/Emphysema	Yes	No	Blood Clots or Clotting Disorder	Yes	No
Hernia	Yes	No	Tuberculosis	Yes	No
If Yes Inguinal? Hiatal?			HIV or AIDS	Yes	No
Diverticular Disease	Yes	No	Diabetes	Yes	No
Hemorrhoids	Yes	No	***If Yes, year of onset*** _____		
Rectal Bleeding	Yes	No	Thyroid disease or Goiter	Yes	No
Ulcers of Stomach or Duodenum	Yes	No	Glaucoma	Yes	No
Gallbladder Disease	Yes	No	Seizures or Epilepsy	Yes	No
Hepatitis or Liver Disease	Yes	No	Parkinson's Disease	Yes	No
Pancreatitis	Yes	No	Multiple Sclerosis	Yes	No
Crohn's Disease	Yes	No	Other Neurologic Problems	Yes	No
Colitis	Yes	No	Skin Condition(s)	Yes	No
Irritable Bowel Syndrome	Yes	No	Severe Anxiety	Yes	No
			Depression	Yes	No
			Psychiatric Treatment	Yes	No

DO YOU HAVE?

Dentures	Yes	No	Hearing Aid	Yes	No
Glasses?	Yes	No	Pacemaker or internal Defibrillator?	Yes	No
Artificial Joints? Where?	Yes	No	Prosthesis? Type? _____	Yes	No
Are you on a special diet?	Yes	No	Describe: _____		

If you are currently taking chemotherapy, please list the medication and your medical oncologist's name and phone number:

Medication	Medical Oncologist Name	Oncologist Phone

If you have ever had **radiation therapy** in the past, please list the facility and phone number, dates of treatment and area of body treated:

Facility Name	Facility Phone	Treatment Date ___/___/___	Area of the body treated

Radiotherapy Clinics of Georgia
A Partner In The US Oncology Network

Radiotherapy Clinics of Georgia

Patient Initial History (This information is completely confidential.)

Patient ID Label

LIST ALL SURGERIES AND APPROXIMATE MONTH / YEAR **If none check here ☐**

Operation	Month/Year	Name of Hospital or Outpatient Facility
	/	
	/	
	/	

_ Prostate Cancer Patients only: Number of prostate biopsies you have had _____

Did you have difficulty urinating after your most recent biopsy? Yes ◯ No ◯

LIST ALL MEDICATIONS you are currently taking (include prescribed, over-the-counter and herbal/nutritional supplements).
If none, check here ☐

Medication	Dosage	Frequency	Prescribed by

If more space is needed, please use back of this page.

ALLERGIES TO MEDICATIONS: **If none check here ☐**

Medication: _____ **Reaction:** _____
Medication: _____ **Reaction:** _____
Medication: _____ **Reaction:** _____

Are you allergic to x-ray dye? Yes ◯ No ◯ **Describe:** _____

FAMILY HISTORY

Are your parents alive? Mother Yes ◯ No ◯ Father Yes ◯ No ◯
Age and cause of death: Mother: _____
Father: _____

Family history of cancer? **If none, check here ☐**

			Type of Cancer				Type of Cancer
Mother	Yes ◯	No ◯	_____	Father	Yes ◯	No ◯	_____
Grandmother	Yes ◯	No ◯	_____	Grandmother	Yes ◯	No ◯	_____
Grandfather	Yes ◯	No ◯	_____	Grandfather	Yes ◯	No ◯	_____
Sister	Yes ◯	No ◯	_____	Aunt	Yes ◯	No ◯	_____
Brother	Yes ◯	No ◯	_____	Uncle	Yes ◯	No ◯	_____

Any history of prostate cancer in Father ☐ Brother ☐ Uncle ☐ Grandfather ☐
How was it treated? _____

SOCIAL HISTORY (Please check all that apply)

Marital Status ☐Married ☐Divorced ☐Widowed ☐Separated ☐Single ☐Partnered

Spouse/Partner's Name: _____

List Child's Name	Age	City and State (Permanent Address)

Did you ever use tobacco? Yes ◯ No ◯ Do you still use tobacco? Yes ◯ No ◯
If yes, type of products: ☐Cigarettes ☐Pipe ☐Snuff ☐Chew ☐Cigars

Radiotherapy Clinics of Georgia
A Partner In The US Oncology Network

Radiotherapy Clinics of Georgia
Patient Initial History (This information is completely confidential.)

Patient ID Label

Age you started ____? How many packs/day? _____ Age you stopped _____
Did you ever use Alcohol? Yes ○ No ○ Do you still use Alcohol? Yes ○ No ○
If yes, type of products _____
What age did you start _____ ? How much? _____ Age you stopped _____
Did you ever use any illicit drugs? Yes ○ No ○ Do you still use illicit drugs? Yes ○ No ○

WORK HISTORY
Occupation _____ Are you still working? Yes ○ No ○
Were you exposed to cancer causing substances and/or asbestos? Yes ○ No ○ List: _____
Has your illness forced you to stop working? Yes ○ No ○ Date: _____
Has your illness forced significant other to stop working? Yes ○ No ○ Date: _____
Has your illness forced significant other to change hours? Yes ○ No ○ Date: _____

SOCIO-ECONOMIC
Education ☐ Completed High School ☐ Completed College ☐ Other _____
Is English your primary language? Yes ○ No ○ If No, list primary language _____

Religion (optional) _____
Special requirements _____
Home Care Needs _____

FUNCTIONAL STATUS
Please list any physical restrictions you may have _____
_____

REVIEW OF SYSTEMS
Please check any of the following symptoms that have occurred in the last six months. If you do not have any of the listed symptoms in each section, please circle [NONE] above each section.

GENERAL **If none of the following apply, check here ☐**
☐ Weight Loss If yes, _____ pounds over _____ months. Intentional? _____
☐ Loss of Appetite ☐ Fever ☐ Chills ☐ Night sweats
☐ Severe Fatigue ☐ Sleep Problems ☐ Dizziness

HEAD & NECK **If none of the following apply, check here ☐**
☐ Lump(s) ☐ Frequent sore throat ☐ Decreased hearing ☐ Hoarseness
☐ Swollen lymph Nodes ☐ Recurrent colds ☐ Deafness ☐ Dental Problems

RESPIRATORY **If none of the following apply, check here ☐**
☐ Shortness of Breath on Exertion Describe activity which causes or makes worse _____
☐ Shortness of Breath at Rest ☐ Cough
☐ Cough Up Sputum Color? _____
☐ Cough Up Blood How Long? _____

CARDIOVASCULAR **If none of the following apply, check here ☐**
☐ Chest Pain ☐ Fainting Spells ☐ Short of Breath with Lying
☐ Sleep Sitting or Propped Up ☐ Swelling of Feet ☐ Leg Pain While Walking

BREAST **If none of the following apply, check here ☐**
☐ Lump or Mass in Breast ☐ Changes in size, shape or contour of breast
☐ Pain in Breast ☐ Discharge or bleeding from Nipple

GASTROINTESTINAL **If none of the following apply, check here ☐**
☐ Nausea/Upset Stomach ☐ Vomiting ☐ Difficult / Problem Swallowing

☐ Spitting Up, Vomiting Blood ☐ Pain in Abdomen or Stomach ☐ Jaundice
☐ Blood in Stool ☐ Black Tarry Stools ☐ Silver Colored Stools
☐ Diarrhea ☐ Constipation

NEUROLOGIC / PSYCHIATRIC / EYES **If none of the following apply, check here ☐**
☐ Numbness or Tingling Where? _____
☐ Weakness in Part of Body Where? _____
☐ Difficulty Speaking ☐ Difficulty Writing ☐ Difficulty Memory ☐ Difficulty Thinking
☐ Change in Personality ☐ Frequent Headaches ☐ Double Vision ☐ Blurred Vision
☐ Nervousness / Anxiety ☐ Relationship Problems
If you check yes to any of these, how long have you had these problems? _____
Have you seen other doctors for these problems? _____

ENDROCRINE **If none of the following apply, check here ☐**
☐ Excessive thirst ☐ Excessive urination

BLOOD & LYMPH **If none of the following apply, check here ☐**
☐ Excessive Bruising ☐ Excessive Bleeding ☐ Swollen lymph glands

SKIN **If none of the following apply, check here ☐**
☐ Itching ☐ Growths ☐ Rash ☐ Scaling

MUSCULO-SKELETAL **If none of the following apply, check here ☐**
☐ Painful Muscles ☐ Leg Cramps ☐ Varicose Veins
☐ Painful Joints ☐ Swelling ☐ Phlebitis

GENITOURINARY **If none of the following apply, check here ☐**
☐ Pain or Burning or Urination ☐ Blood in Urine ☐ Urgent Urination ☐ Frequent Urination
☐ Get Up at Night to Urinate How Often? _____ ☐ Urination Hard to Start
☐ Leakage or Loss of Bladder Control ☐ Change in Color of Urine

OB-GYN **If none of the following apply, check here ☐**
☐ Unusual Vaginal Bleeding ☐ Unusual Vaginal Discharge
☐ Painful / Difficult Intercourse ☐ Other Sexual Problems
☐ Urinary Leakage

Age at First Period_____ Number of Pregnancies _____
Age at last period _____ Number of Live Births _____
Date of Last Pap Smear _____ Number of Miscarriages _____
Age at First Full-Term Pregnancy _____ Are you Pregnant? Yes ○ No ○
Did you breast feed children? Yes ○ No ○ Length of Breast Feeding _____ Months
Are you sexually active? Yes ○ No ○ Are you taking oral contraceptives? Yes ○ No ○
Have you taken Hormones (i.e. estrogen, progesterone, etc.)
List hormones _____

PAIN MANAGEMENT
Are you in pain now? Yes ○ No ○ List location _____
Does medication relieve pain? Yes ○ No ○
Rate your pain on a scale of 1-10, 1 being best, 10 being worst _____
When does your pain occur? _____

Radiotherapy Clinics of Georgia
A Partner In The US Oncology Network

Radiotherapy Clinics of Georgia
Patient Initial History (This information is completely confidential.)

Patient ID Label

INTERGRATIVE ONCOLOGY PROGRAM

How did you first hear about Radiotherapy Clinics of Georgia?

☐ Physician referral	Name of referring MD_____
☐ Billboard	Location of Billboard_____
☐ Prior Patient	Patient's Name _____
☐ Radio/TV	Station/program _____
☐ Internet	Website _____
☐ Magazine/Newspaper	Name _____
☐ Other	Please specify _____

To receive questionnaire reminders, newsletters, educational material, event invitations, and other information about RC Cancer Centers please provide us with your email address: _____

(*Your email address will be kept private and will not be shared or sold to anyone outside of the Radiotherapy Clinics of Georgia organization.*)

I acknowledge that the information provided above is true and correct to the best of my knowledge.

I acknowledge that I have been made aware that Radiotherapy Centers of Georgia does NOT honor Advance Directives. I realize that in the case of an emergency, I will be transported to the nearest emergency department for treatment.

Signature: _____ Date: ____/____/_____

Reviewed by Physician: _____ Date: ____/____/_____

Authorization for Release of PHI to Caregivers

(For individuals directly involved in the patients care or payment for care.)

I, _____, authorize the following persons(s) (spouse, partner, sibling, child, friend, etc.) access to my private health information (PHI).

Name (Printed): _____ Relationship: _____ Date of Birth: ____/____/____ Phone Number _____
Name (Printed): _____ Relationship: _____ Date of Birth: ____/____/____ Phone Number
Name (Printed): _____ Relationship: _____ Date of Birth: ____/____/____ Phone Number

I understand that these persons are authorized to access my information until that authorization is revoked. Authorization can be revoked verbally or in writing at any time by me (patient) or an appointed Durable Health Care Power of Attorney.

Signature of Patient: _____

Name (Printed): _____ Date: ____/____/____

Personal Representative

I, _____ , attest that I can act on behalf of _____ (patient) for purposes of treatment authorization and or Use and Disclosure of the patients PHI through rights afforded to me by the state. I will provide all legal documentation required to support the above statement. (Please attach legal documentation to this form).

Examples:

- Durable Power of Attorney for Health Care
- Health Care Proxy
- Court-Appointed Guardian
- Letters of Testamentary/Administration

Signature: _____

Name (Printed): _____ Date ____/____/____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information is being requested for:

_____ _____ _____/_____/_____
Last Name MI First Name Maiden/Other Name Date of Birth

_____ _____
Phone# Address City State Zip

Date(s) of service requested: _____/_____/_____ - _____/_____/_____
From To

Release the medical information from:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Disclose the medical information to:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Requested medical information authorized to be released: (check items authorized to be released)

- ☐ Consult/H&P
- ☐ OP Report/Procedure Report
- ☐ Follow-up notes
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Weekly CBC reports
- ☐ PSA scores
- ☐ All Labs
- ☐ Tumor Markers
- ☐ Pathology Reports
- ☐ Pathology Slides
- ☐ EKG
- ☐ All CT scans /X-rays /Ultrasound
- ☐ Mammograms
- ☐ Radiotherapy treatment records
- ☐ Entire chart
- ☐ Chemotherapy Flow Sheet
- ☐ Other_____

To the extent applicable, I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate(s) that I permit information of this type, if it exists, to be released. I understand that **IF** I do check the box, _____ will release such information about me if it exists.

- ☐ HIV/AIDS infection
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Sexually transmitted diseases
- ☐ Genetic
- ☐ Mental Health

Note: This authorization is for treatment, payment, or healthcare operations purposes unless otherwise described in the space provided below. While every attempt will be made to protect the privacy of your health information, please note that release of your health information to an authorized person or organization could be the subject of re-disclosure by the recipient and therefore no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) or other federal or state laws. This authorization will expire within ***365 days*** unless you specify otherwise. You have the right to revoke this authorization in writing except to the extent that we have released information prior to a revocation. To revoke authorization send written request to: **Manager of Radiation Services, 311 Philip Blvd., Lawrenceville, GA 30046.** You have the right to request your records be provided in electronic format if available.

I understand that my health information is protected by federal and state privacy laws and cannot be disclosed without my written consent except as specifically provided by law.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here below.

_____

_____

_____ _____ _____/_____/_____
Signature of Patient or Representative* Relationship to Patient* Date
Supporting documentation must be provided

_____ _____/_____/_____
Signature of Parent/Guardian (minors age 0-17) Date

Attention Staff: This form may only be completed when there is a need to request medical records/from which you are releasing records/films and must be completed in full for each entity from which you are releasing records or to which you are sending records.Under HIPAA, this form is not necessary in order to share or obtain medical information for treatment or payment purposes of the current medical illness. This form is only valid if completely filled out.

Assignment of Benefits

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Radiotherapy Clinics of Georgia** (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: _____ Date: _____

Medigap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medigap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medigap insurer listed below any information needed to determine benefits payable for services from the Provider.

Medigap Insurance Name: _____

Patient/Guardian Signature: _____ Date: _____

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature: _____ Date: _____

Receipt of HIPAA Patient Privacy Rights Notification

My signature below indicates that I have received the HIPAA Patient Privacy Rights Notification and that I have been made aware of my privacy rights and how I may exercise those rights. I understand that all contact phone numbers listed on the Patient Registration Form may be used to contact me for treatment or payment purposes unless I submit a written request to restrict the use of any/all contact phone numbers listed.

Patient/Guardian Signature: _____ Date: _____

Fundraising Communications Op-Out

By checking the box below I indicate that I do not want to receive any fundraising communications from my Provider.

☐ I do not want to receive any fundraising communications

Patient/Guardian Signature: _____ Date: _____

Date: _____ Patient RT#: _____

_____ _____/_____/_____ _____
First Name MI Last Name Date of Birth Age

_____
Address Apt# City State Zip County of Residence

_____
☐ Home Phone ☐ Work Phone ☐ Cell Phone

_____
☐ Secure e-mail ☐ Mail (to address above) *Check your preferred method of contact*

Attention: We will use all phone numbers listed above to contact you as necessary for treatment and payment purposes unless you place a restriction on the use of these numbers in writing.

Social Security # (*optional):* _____ Sex: **OM OF** Marital Status: **OS OM OW OD**

Preferred Language: _____ **Ethnicity**: _____

☐Do not want to provide ☐Do not know **Race**: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White

Employed: **NO YO** Retired: **NO YO**_____ Disabled: **NO YO**_____
Date Date

Employer: _____ Occupation: _____

Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice? O Yes O No

NOTE: If NO, Patient or Caregiver must immediately notify staff if Patient is admitted to a hospital, SNF, Convalescent Home, or Hospice.

Name of Facility _____ Phone _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

_____
Primary Insurance Medical Group (HMO) ID# Group #

_____
Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

_____
Secondary Insurance Medical Group (HMO) ID# Group#

_____/_____/_____
Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

_____
Primary Care Physician Phone

_____
Referring Physician Phone

EMERGENCY CONTACT

_____
Name Phone Relationship

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

Patient/Guardian Signature:_____ Date: _____

PROSTRCISION QUESTIONNAIRE

These questions are to monitor your urinary and bowel symptoms before during and after treatment. Answers to these questions are extremely important. We use this information to determine how to give irradiation or treat any problems that might arise after treatment. We also use this information to compare how you are doing with all other men at the same time after implant.

Please answer according to how you have been over the past 6 or 12 months, based on your follow-up schedule (Bi-Annual or Annual Follow-Up Schedule).

Please place your answers on the enclosed answer sheet.

URINATION

1. Have you noticed any blood in your urine?

- 1. No
- 2. Yes, about once per month or less often
- 3. Yes, weekly
- 4. Yes, daily
- 5. Yes, severe blood loss

2. Do you leak urine?

- 1. No, except perhaps just a few drops right after urination
- 2. Yes, when I get the urge to urinate I have passed some urine before I got to the toilet
- 3. Yes, I leak some urine when I cough or lift something
- 4. Yes, I leak doing almost anything
- 5. Yes, no control at all, wear catheter

3. If you leak urine, how much do you leak?

- 1. None, except I might pass a few drops just after urination
- 2. Just a few drops in my underwear, I do not need a pad
- 3. I need a pad sometimes, but not all the time
- 4. I need a pad all the time

4. Overall, how bothersome are your urinary symptoms?

- 1. Not bothersome
- 2. Minimal and occasional bother
- 3. Mild bother
- 4. Moderate bother
- 5. Severe bother

RECTAL

5. On average, how many bowel movements do you have each day?

_____

6. Have you lost control of your bowels before getting to the toilet?

- 1. No
- 2. Yes, less than once a month, do not need pad
- 3. Yes, monthly, sometimes wear pad
- 4. Yes, weekly or more, wear pads most of the time
- 5. No control at all, wear pad all the time

7. Have you noticed any blood with your bowel movements?

- 1. No
- 2. Yes, about once per month or less often
- 3. Yes, 1-2 times per week
- 4. Yes, daily
- 5. Yes, severe blood loss

8.Overall, how bothersome have your bowel movements been?

- 1. Not bothersome
- 2. Minimal and occasional bother
- 3. Mild bother
- 4. Moderate bother
- 5. Severe bother

Answer Sheet for ProstRcision Questionnaire

Name: _____ Date: _____

Implant No. _____ FU (Months Post Implant) _____

PATIENT SECTION	
Patient	Score
Urinary	
1. Blood 2. Leak, when 3. Leak, amount 4. Bother	
Rectal	
5. Frequency 6. Bowel Control 7. Blood 8. Bother	

Check any urinary surgery you have had since last seen:			
2. Catheter	☐	9. Cauterize	☐
4. Cytoscope	☐	11. Artifical Sphincter	☐
5. TURP	☐	12. Urethral Dilation	☐
6. Orchiectomy	☐	13. TUIP	☐
8. Biopsy	☐	99. Other	☐

Check any erection aids you are currently using:			
1. Penile injection	☐	4. Penile Implant	☐
2. Muse	☐	5. Viagra, Cialis, Levitra, Siendra	☐
3. Vacuum Pump	☐		

Check any medications you are currently taking below:	
Urinary Medications	
1. None	☐
2. Pyridium, Urised, Prosed, UTA	☐
3. Urospas, Ditropan, Enablex, Levbid, Detrol, Vesicare, Sactura, Mybetriq	☐
4. Cardura, Hytrin, Flomax, Uroxatral, Rapaflo	☐
5. Narcotics	☐
6. Hormones (Lupron, Zoladex, Casodex, Flutamide, Eligard, Trelstar, Firmagon)	☐
7. Antibiotics	☐
8. Saw Palmetto	☐
9. Proscar, Avodart	☐
10. Advil, Cranberry Pills	☐
11. Coumadin, Aspirin, Lovenox, Plavix	☐
12. Other	☐

Rectal Medications			
1. None	☐	5. Immodium, Lomotil	☐
2. Cortisone Suppository	☐	6. Azulfidine	☐
3. Rowasa	☐	7. Other	☐
4. Narcotics	☐		

PHYSICIAN SECTION	
Physician	Score
9. PSA	
10. Disease Status	
11. AUA Score	
12. Urinary Medication	
13. Urinary Surgery	
14. SHIM Score	
15. Erection Aid	
PHYSICIAN NOTES	
Initials:	Date:

We have updated our privacy policies. Your signature below confirms that the information on this survey is correct to the best of your knowledge and that you have read and agree to the Research Study Patient Information and Informed Consent Form distributed with this survey.

Patient Signature:_____ Date: _____

American Urological Association (AUA) Questionnaire on Urinary Function

Name _____ Date _____

Implant # _____ ☐PRE ☐IMP ☐XRT ☐FU (Months after implant) _____

		Circle your score for each below						
		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	YOUR SCORE
1	**Incomplete Emptying** Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	0
2	**Frequency** Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	0
3	**Intermittency** Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	0
4	**Urgency** Over the past month or so, how often have you found it difficult to postpone urination?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	0
5	**Weak-stream** Over the past month or so, how often have you had a weak urinary stream?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	0
6	**Straining** Over the past month or so, how often have you had to push or strain to begin urination?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	0
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?	○ None 0	○ 1 time 1	○ 2 times 2	○ 3 times 3	○ 4 times 4	○ 5 times or more 5	0
							Total your score here. Total Symptom Score = Sum of Questions 1 to 7 =	0

From the American Urological Association

(AUA) Symptom Index for BPH

Revised: 02/22/2022

SEXUAL HEALTH INVENTORY FOR MEN

PATIENT NAME: _____ DATE OF EVALUATION_____

IMPLANT #: _____PRE○ IMP○ XRT○ FU○ (Months after implant) _____

Please answer these six questions on erections using **ONLY ONE** of the possible answers under each question.

If you are ***not*** taking an **Erectile Dysfunction (ED)** drug, please put your answers in the "Natural" column labeled "**A**".

If you ***are*** taking an **Erectile Dysfunction (ED)** drug, please answer **BOTH** according to how your erections are **WITHOUT** the ED drug in column "**A**" (Natural) and **WITH** the ED drug in column "**B**".

Are you currently taking an ED Drug? ○**No** ○ **Yes (choose one)** ***1. Viagra*** ○ ***2. Cialis*** ○ ***3. Levitra*** ○

If yes, please circle dose: **Viagra: ○25 ○50 ○100** **Cialis: ○5 ○10 ○20** **Levitra:○5 ○10 ○20**

	"A" NATURAL (No ED)	**"B" WITH ED Drug**
Over the past 4 weeks:		
1. **How do you rate your confidence that you could get and keep an erection?**	**A._____**	**B._____**
1. Very low 2. Low 3. Moderate 4. High 5. Very High		
2. **When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?**	**A._____**	**B._____**
0. No sexual activity 1. Almost never or never 2. A few times (much less than half the time) 3. Sometimes (about half the time) 4. Most times (much more than half) 5. Almost always or always		
3. **During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?**	**A._____**	**B._____**
0. Did not attempt intercourse 1. Almost never or never 2. A few times (much less than half the time) 3. Sometimes (about half the time) 4. Most times (much more than half) 5. Almost always or always		
4. **During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?**	**A._____**	**B._____**
0. Did not attempt intercourse 1. Extremely difficult 2. Very difficult 3. Difficult 4. Slightly Difficult 5. Not difficult		
5. When you attempted sexual intercourse, how often was it satisfactory for you?	**A._____**	**B._____**
0. Did not attempt intercourse 1. Almost never or never 2. A few times (much less than half the time) 3. Sometimes (about half the time) 4. Most times (much more than half) 5. Almost always or always		
SCORE: ADD Q1-Q5 Here:	**A.**0**_____**	**B.**0**_____**
6. How often do you have sexual intercourse with a partner?		
1. I am capable of satisfactory sexual intercourse, but I have not attempted in the last six month or since last filling out this form. 2. Not at all, I cannot get an erection. 3. Less than once a month 4. 1 to 3 times a month 5. 1 time a week 6. 2 to 3 times a week 7. More than 4 times a week.	**A._____**	**B._____**

Revision date: 2/02/2022

PHYSICIAN LIST

Patient name: _____ Date: _____

Please list the names, addresses and phone numbers of physicians that you are seeing. If you do not have all the information with you at the tim eof your visit, please call us when you get home. This information is very important so that we can inform your physicians of your progress.

Primary Physician: _____

Address: _____

_____

Phone: _____

Referring Physician: _____

Address: _____

_____

Phone: _____

Medical Oncologist: _____

Address: _____

_____

Phone: _____

Surgeon:: _____

Address: _____

_____

Phone: _____

OB/GYN:: _____

Address: _____

_____

Phone: _____

Other Physician:: _____

Address: _____

_____

Phone: _____