Lake Sumter Urology

808, Hwy 466 • Lady Lake, FL 32159 Tel: 352.775.6899 • Fax: 352.775.8125 lakesumterurology.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Sex:** ☐ Male ☐ Female Please circle: Married Divorced Single Widow
- **Phone Number:** _____ Cell Number: _____
- **Email Address:** _____
- **Pharmacy Name And Location:** _____

Home Address: _____

- **Emergency Contact Name:** _____
- **Emergency Contact Phone:** _____
- **Primary Care Provider:** _____
- **Referring Provider (if any):** _____

Insurance Information

- **Primary Insurance Carrier:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Policy Holder Name:** _____
- **Relationship to Patient:** _____

Medical History

Current Symptoms (check all that apply)

- ☐ Frequent urination
- ☐ Pain or burning with urination
- ☐ Blood in urine
- ☐ Incontinence or leakage
- ☐ Trouble starting or stopping urine stream
- ☐ Nocturia (nighttime urination)
- ☐ Pelvic or flank pain
- ☐ Erectile dysfunction
- ☐ Testicular pain or swelling
- ☐ Other: _____

Past Urologic Conditions (check all that apply)

- ☐ Kidney stones
- ☐ Recurrent UTIs
- ☐ Enlarged prostate/BPH
- ☐ Prostate cancer
- ☐ Bladder cancer
- ☐ Overactive bladder
- ☐ Interstitial cystitis
- ☐ Incontinence
- ☐ Other: _____

Surgical History

- **List all past surgeries:**

_____

_____

Medications

- **List current medications and dose:**_____

_____

_____

_____

Allergies

- **List medication or material allergies:**

_____

_____

Social History

- **Tobacco Use:** ☐ Never ☐ Former ☐ Current
- **Alcohol Use:** ☐ None ☐ Occasional ☐ Regular
- **Recreational Drugs:** ☐ Yes ☐ No — If yes: ____

_____

Family History

Check any conditions in immediate family:

- ☐ Kidney stones
- ☐ Prostate cancer
- ☐ Bladder cancer
- ☐ Kidney disease
- ☐ Incontinence

_____

Review of Systems

Please check any symptoms you are experiencing:

- **General:** ☐ Fever ☐ Fatigue ☐ Weight loss
- **Cardiac:** ☐ Chest pain ☐ Palpitations

- **Respiratory:** ☐ Shortness of breath ☐ Cough
- **GI:** ☐ Nausea ☐ Constipation ☐ Diarrhea
- **Musculoskeletal:** ☐ Back pain ☐ Joint pain
- **Neurological:** ☐ Dizziness ☐ Numbness

Consent to Treat

I consent to evaluation and treatment by the urology providers at this clinic. I understand that this may include physical examinations, diagnostic tests, and medical or surgical recommendations.

Signature: _____

Date: _____

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ASSIGNMENT OF BENEFITS

Medicare, Medigap, General Assignment of Benefits and receipt of HIPPA information

I request the payment of any of the above payments be made on my behalf to Lake Sumter Urology, LLC for any services rendered to me by my provider. I have received the HIPPA patient privacy rights, and I am aware of my privacy rights and how to exercise them.

_____	_____	_____
Print Signature	Patient Signature	Date

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

Please list who we can discuss your information with.

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

I understand that under the Health Insurance Portability and Accounting Ac of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly or indirectly
- Electronically exchange records with other healthcare providers and organizations
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis
- Access drug benefit coverage and medication history

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent at any time except to the extent that you have taken action relying on this consent.

Patient Name:_____

Patient Signature:_____

Date:_____

Inability to Obtain Acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe in good faith efforts made to obtain the individual's acknowledgment and the reasons why the acknowledgment was not obtained.

LSU, LLC. Signature: _____

Date: _____

Ph: 352-775-6899
Fax: 877-319-1879

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International Prostate Symptom Score (IPSS)

Patient Name: _____ Today's Date: _____

Phone Number: _____ Date of Birth: _____

If you are taking BPH medications, please rate the overall effectiveness of those medications				
No Relief/No Longer Effective	Minimal Relief	Moderate Relief	Good Relief	Very Good Relief

Are you currently experiencing any of these symptoms? (circle all that apply)									
Dizziness	Headaches	Fatigue	Insomnia	Nasal Congestion	Depression	Issues with Ejaculation	Erectile Dysfunction	Decreased Sex Drive	Breast Development

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 have you found you stopped and started again several times when you urinated?	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?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

0 no symptoms	1 – 7 mild symptoms	8 – 19 moderate symptoms	20 – 35 severe symptoms

Total International Prostate Symptom Score = _____

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

Quality of Life (QoL)

	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
Would you be interested in learning about a minimally invasive option that could allow you to avoid or discontinue enlarged prostate medications?						Yes	No

The information provided in this form may be de-identified and aggregated and provided to the manufacturer of the UroLift™ System.

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**