Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION - PLEASE PRINT

Last Name:
Suffix:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone:

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:

Employer Information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex:
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex:
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Center for Urologic Cancer
FLORIDA HOSPITAL MEDICAL GROUP

REFERRAL INFORMATION

How did you hear about us?(Name)_____

Present or Past Occupation: _____

Retired? ☐ **Yes** ☐ **No** **If so, when?** _____/_____/_____

Employer Name:_____

Primary Care/Family Doctor Name: **Dr.**_____

Phone: (_____)_____Fax: (_____)_____

Address, City, State, Zip:_____

Did your Primary Care/Family Doctor refer you to Dr. Patel? ☐ Yes ☐ No
Do you want records forwarded to your Primary Care/Family Doctor? ☐ Yes ☐ No

Urologist Name: **Dr.**_____

Phone: (_____)_____ Fax: (_____)_____

Address, City, State, Zip:_____

Did your urologist refer you to Dr. Patel? ☐ Yes ☐ No
Do you want records forwarded to your urologist? ☐ Yes ☐ No

If you were **NOT** referred by your Primary Care/Family Doctor or your Urologist, please provide us your Referring Physician information below.

Referring Physician Name: **Dr.**_____

Phone: (_____)_____ Fax: (_____)_____

Address, City, State, Zip:_____

Do you want records forwarded to your referring physician? ☐ Yes ☐ No

Are you currently under the care of a cardiologist? ☐ Yes ☐ No

Cardiologist Name: Dr._____

Phone: (_____)_____ Fax: (_____)_____

Address, City, State, Zip:_____

CELEBRATION HEALTH
PHARMACARE

As part of the discharge process, PharmaCare Center Pharmacy will have your prescriptions ready before you leave the hospital. This will save you time and enable you to begin your recovery sooner.

Please provide the following information and a legible copy of your pharmacy insurance card. (Often a different card than your medical insurance card):

Patient Name:_____

Pharmacy insurance plan name:_____

RX BIN #:_____ **RX PCN #:**_____

RX ID #:_____ **RX Group #:**_____

Is this plan under your name? Yes___ **No**___

If not, what is your relationship to the cardholder?_____

***co-pays or amount due is expected at prescription pick up.**

Do you have any allergies to medication? If so, please list medication and type of reaction:

_____

_____

Please list any current prescription or over-the-counter medications you are currently taking:

_____ _____ _____

_____ _____ _____ _____

_____ _____ _____

For your convenience, your co-pays or amount due can be charged to your credit card and delivered to your room.

Cardholder name:_____

Card #:_____ **Expiration Date:**_____

Security Code (on back of card):_____ **Cardholder signature:**_____

SURGERY OUT-OF-POCKET EXPENSE

If you have any questions regarding your health insurance coverage and out-of-pocket expenses, please contact your insurance company directly at the customer service number located on the back of your insurance card. It is the patient's responsibility to know his/her own insurance benefits.

You will be contacted by our office and the hospital prior to your surgery for collection of your physician fees and hospital copayment, if applicable. Our office will contact you within 21 days of your scheduled surgery date to collect any applicable fees.

Two weeks prior to your scheduled surgery our office will obtain authorization for your surgery from your insurance company. Approved authorizations are automatically sent to the hospital unless there is a denial of your procedure, in which case you will be contacted directly by our office. If you happen to change insurance carriers, please notify us immediately of any changes in your health insurance coverage.

Below is a list of information that you may be asked for by your insurance company when verifying your benefits. Please select the diagnosis and procedure code related to your diagnosis. When verifying your benefits with your insurance plan we highly encourage you to inquire if the surgery would be covered as inpatient or outpatient as you out of pocket costs could be considerably different.

Diagnosis Code:		Surgery Procedure Codes:
Prostate Cancer: C61	**>**	Robotic Prostatectomy-55866
Enlarged Prostate/ BPH: N40	**>**	Robotic Prostatectomy-55866
Renal Mass: N28.89	**>**	Robotic Partial Nephrectomy- 50543
Renal Mass: N28.89	**>**	Robotic Radical Nephrectomy-50545
Elevated PSA: R97.2	**>**	MRI Fusion Biopsy- 55700

Dr. Patel's Information:
Tax ID: 593214635 (Florida Hospital Medical Group, Dr. Vipul Patel)
NPI: 1942259908

Hospital Information: Florida Hospital Tax ID: 590724459
Florida Hospital - Celebration Health
400 Celebration Place
Celebration, FL 34747
407-303-4000

Contact information for other professional services that will be utilized for your surgery and billed separately:

US Anesthesia Partners (USAP): Please leave a message and someone will return your call: 407-667-0505, ext. 300. Tax ID: 592905984

QSS Southeastern Clinical Services: (Ask for Jeff Canitia)
407-830-1309. Tax ID: 593137319, Surgical Assistant, Edmund Abate, PA-C
NPI:1205820206

Remember, it is your sole responsibility to know and check your health insurance coverage directly with your insurance company as this is confidential information.

_____ _____

Patient Name DOB

_____ _____

Patient Signature Date

Center for Urologic Cancer

FLORIDA HOSPITAL MEDICAL GROUP

410 Celebration Pl Suite 200
KISSIMMEE, FL 34747-5432
Phone: 407-303-4673, Fax: 407-303-4674

Form of Written Acknowledgment of Receipt
of FLORIDA HOSPITAL MEDICAL GROUP INC.'s Notice of Patient Privacy Practices

By signing this Written Acknowledgment of Receipt of FLORIDA HOSPITAL MEDICAL GROUP INC.'s Notice of Patient Privacy Practices("Acknowledgment"), I hereby expressly acknowledge my receipt of FLORIDA HOSPITAL MEDICAL GROUP INC.'s Notice of Patient Privacy Practices.

_____
Patient, or Legal Representative, Signature

_____
Printed Patient, or Legal Representative, Name (or label)

_____
Date

Acknowledgment **NOT** obtained because:

_____ Patient, or legal representative, declined Notice of Patient Privacy Practices;

_____ Patient treated in an emergency room and discharged before obtaining Acknowledgment;

_____ Other (briefly describe)_____

_____
Employee Signature

_____
Employee Printed Name

_____
Date

Center for Urologic Cancer

FLORIDA HOSPITAL MEDICAL GROUP

*

410 Celebration Pl Suite 200
KISSIMMEE, FL 34747-5432

General Consent and Service Terms

General Consent for Treatment

I agree to allow FLORIDA HOSPITAL MEDICAL GROUP INC and its Physicians to provide all health care services to me that are routine or otherwise deemed necessary. I understand I have the right to refuse consent to any proposed procedure or treatment at any time prior to receiving it. I understand that any treatment involving material risks will be explained to me and that I will have the opportunity to ask questions about the associated risks, alternatives and prognosis before allowing the treatment to be performed. I agree that no guarantees have been given to me as to the outcome of any treatment. I agree my picture can be taken to identify me.

General Sharing of Health Information

I agree to the Medical Group, its affiliates, and Physicians using and sharing all of my health information, including but not limited to Highly Confidential Information (see definition below), for payment, my continued treatment, and healthcare operations. This includes sharing my information with the following

All physicians and other medical service providers associated with my treatment, other entities owned or managed by Adventist Health System, as well as other physicians who are participating in integrated physician plan networks or Health Information Exchanges.

Business partners of the Medical Group, its affiliates, and Physicians, who provide administrative, operational, financial, legal and technical support services.

All insurance Payer(s) and healthcare plans responsible for paying or determining if I am eligible for payment for my treatment.

Substance, Drug, and Alcohol Abuse Authorization

I authorize and have initialed below for the Medical Group, its affiliates, Physicians, and Adventist Health System to release; should any exist, all of my substance abuse and drug and alcohol abuse health information to the Medical Group's affiliates for my treatment, payment for my treatment, and the healt care operations of the Medical Group, its affiliates, and Physicians. I understand this authorization may be cancelled at any time, unless the Medical Group its affiliates, and Physicians have already acted and relied on it. If not previously revoked, I understand this authorization is effective until I am deceased.

Initial here: _____

Insurance Assignment and Payment

I permanently assign my third party payer benefits payable directly to the Medical Group. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

I understand and agree that payment of my out-of-pocket portion for all elective services must be paid 10 days prior to receiving the service or the service will be cancelled and then rescheduled when such payment is received. If I do not pay for all of my services and an attorney or collection agency asks me t pay, I agree to pay the reasonable attorneys' fees and/or collection expenses in addition to paying for the cost of all my services.

I authorize the Medical Group to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance or third party payer will not direct payment to the Medical Group, I agree to forward to the Medical Group all health insurance payments which I receive for the services rendered by the Medical Group.

Unless otherwise designated by the payer, I understand the Medical Group posts all payments received to the oldest balances first, with the exception of copays, drugs, and supplies. I give permission to apply any credit balances to offset amounts due to the Medical Group or other Medical Groups owned by Adventist Health System where I have received services for current accounts or accounts I have not paid yet.

I authorize the use of my signature below on all insurance submissions. I may at any time in the future cancel this authorization in writing.

_____ _____

Patient Name Date of Birth

Medicare Assignment of Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Self-Pay Request

If I do not want my insurance company(ies) to receive health care information about this treatment I understand I will need to inform the staff and complete the Request to Restrict Use and Disclosure of Protected Health Information form.

Communication

Messages and Mail:
I understand you may communicate with me through US Mail, electronic mail, telephone or voice mail messages, to remind me about my appointments, treatment follow-up or to tell me about new services that are available. I understand that I must tell you if I do not want you to communicate with me like this.

Sharing PHI with family and friends:
I understand you will share my PHI with the family members, friends, or other individuals who are present with me unless I tell you otherwise.

Wireless Calls and Texting:
I agree and have initialed below for the Medical Group and its affiliates to use an automated telephone dialing system, and texting, to contact the cellular telephone number(s) that I provided for appointment, treatment, and payment purposes.

Initial here: _____

Signatures

BY SIGNING BELOW, I AM AGREEING TO THE PERMISSIONS, AGREEMENTS, AND AUTHORIZATIONS DESCRIBED IN THIS AGREEMENT. I HAVE READ THIS AGREEMENT AND HAVE BEEN ABLE TO ASK QUESTIONS. I UNDERSTAND THIS AGREEMENT IS VALID FOR ONE YEAR FROM THE DATE I SIGN IT.

Printed Name of Patient or Legal Representative: _____ Date: _____

Patient or Legal Representative Signature: _____ Date: _____

Relationship of Person signing if not Patient: _____

Please review the highly confidential information as defined by your state:

Florida:	Mental health, HIV/AIDS, genetic testing, venereal disease, and tuberculosis information
Georgia:	Mental health and HIV/AIDS information
Kansas:	Mental health and HIV/AIDS information
Kentucky:	Mental health, HIV/AIDS, genetic testing, family planning, venereal disease, sickle cell anemia, abortion, and rape/sexual assault information
North Carolina:	Mental health, HIV/AIDS, and venereal disease information
Wisconsin:	Mental health, HIV/AIDS, and venereal disease information

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of:

Patient Name:	MR#:	DOB:
Address:		SSN:
City, State, Zip:		Telephone:

Email address:

Release Information From:	Release Information To:
_____ (Name of facility, person, company)	_____ (Name of facility, person, company)
_____ (Street address or PO Box, City, State, Zip)	_____ (Street address or PO Box, City, State, Zip)
_____ (Telephone number) | (Fax number)	_____ (Telephone number) | (Fax number)

Dates of treatment for records to be released: Treatment dates from: __/__/____ to: __/__/____

Hospital Abstract (check all that may apply)
☐ Consultation reports ☐ Diagnostic Test Results ☐ Medications ☐ History & Physical ☐ Discharge Summary ☐ Operative Reports Substance ☐ Abuse Records
☐ Allergies ☐ Physician Orders ☐ Progress Notes ☐ Emergency Record ☐ Cardiac Reports/EKG ☐ Laboratory Reports ☐ Mental Health ☐ HIV/AIDS Information
☐ Radiology/XRay Reports ☐ Pathology Reports ☐ Billing Information ☐ Mental Health Records ☐ Developmental Disability Records ☐ Therapy Notes
☐ Other: _____
☐ Entire Record (not including psychotherapy notes)

Office/Clinic Abstract (check all that may apply)
☐ Office Visits ☐ Physical Exam ☐ Consultation Reports ☐ Diagnostic Test Results ☐ Laboratory Reports ☐ Medications ☐ Billing Information
☐ Mental Health ☐ Developmental Disability Records ☐ Substance Abuse Records ☐ HIV/AIDS Information ☐ Therapy Notes
☐ Other: _____
☐ Entire Record (not including psychotherapy notes)

To be completed by requester: (select one)
☐ Paper Copy ☐ Electronic Copy
☐ CD (Charges may apply) ☐ Other: _____

Delivery Method:
☐ US Mail ☐ Pick-up ☐ Fax ☐ e-Mail: _____
☐ Other: _____

I have read this authorization form and understand the following statements:

- **I am giving the Office Practice permission to release my health information.**
- **I understand that I may cancel this permission at any time by notifying the Office Practice ins writing, but if I do, it will not impact any actions the Office Practice took before I canceled this authorization.**
- **I understand that permitting the release of my health information is my choice. I can refuse to give permission for releasing my health information. I understand the Office Practice may not require me to sign this form before I am treated. I understand that any health information released could then be shared again with another person or entity and that my health information may not be protected by federal law.**
- **I understand the Office Practice may be allowed by law to deny my request to access or receive a copy of all or part of my health information and that I will receive a written notice explaining why my request was denied.**
- **I understand I may have to pay for a copy of my records.**
- **I understand I may receive a copy of this signed authorization form.**

I have read this form and agree to the release of my health information as written above.

Patient Signature: _____ Date: __/__/____
Printed Name of Authorized Representative/Parent: _____ Date: __/__/____
Relationship to Patient: _____
Address and Phone Number of Authorized Representative/Parent: _____
_____

FOR OFFICE USE ONLY

Date of Release: __/__/____ via ☐ US Mail ☐ fax ☐ e-Mail ☐ Other: _____ ☐ ID Verified ☐ DL/Other ID: _____
Employee Name & Title: _____ Employee User ID: _____ Date: __/__/____

Note to recipient of alcohol or drug abuse records: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AdventHealth
Medical Group

Patient History Form

Date_____

Name_____

Date of Birth_____ Age_____ Height_____ Weight_____lbs

List all Medications:_____

_____

_____

List any food/drug allergies:_____
Do you have an iodine or shellfish allergy?_____
Have you ever had a reaction to CT dye? If yes, explain_____
_____

Are you allergic to latex?_____
Have you had a history of MRSA? _____
Have you had a history of VRE? _____

Medical History- please mark if you have or have ever had any of the following:

PLEASE GIVE DATES OF DIAGNOSIS!!

☐ Cancer - Type?_____ ☐ Chest pain _____

☐ High Blood pressure_____ ☐ Diabetes _____

☐ Kidney Stones _____ ☐ Stroke _____

☐ Heart Disease - Type?_____

☐ Lung disease/COPD/emphysema_____

☐ Blood clot(legs, arms, lung) –Where?_____

☐ Thyroid problems_____ ☐ Stomach ulcer_____

☐ Kidney disease_____ ☐ Glaucoma_____

☐ Blood transfusion _____ ☐ Gun shot/stab wound_____

☐ Bleeding disorder-specify_____ ☐ Lupus_____

☐ Other medical problems NOT listed;

_____

_____

_____

Surgical History- please mark if you have had any of the following procedures:
PLEASE GIVE DATES!!

☐ Cardiac stent _____ ☐ Heart by-pass_____

☐ Back surgery- Fusion? Hardware? _____

☐ Gall bladder_____ ☐ Stomach_____

☐ Heart valve_____ ☐ Pacemaker_____

☐ Hernia; where?_____

☐ Hysterectomy_____ ☐ Tonsils _____

☐ Appendix_____ ☐ Rectal/Intestinal_____

☐ Transplants-Organs? Stem cell? _____

☐ Joint replacement? Where? _____

Other surgery not listed above: _____

_____

_____

Urological History- please mark if you have had any of the following:
PLEASE GIVE DATES!!

☐ TURP_____ ☐ Cystoscopy_____ ☐ Hormone therapy_____

☐ Bladder surgery_____ ☐ Kidney surgery_____

☐ Kidney Stone removal_____

☐ Radiation treatment- where?_____

Other urological history not stated above: _____

_____

AdventHealth
Medical Group

Social History:

Married ? ☐ yes ☐ no

Tobacco use? ☐ yes ☐ no packs per day_____ how many years_____
Quit? When?_____

Alcohol use? ☐ yes ☐ no How many drinks per day?_____
What type of alcohol?_____

Please note that your care may need to be altered based on alcohol and tobacco use. Please be accurate in your answers to your questions so that we may take proper care of you!

Family History-Please mark if anyone in your family has had the following conditions:
Please tell us their relationship to you…(ie Father, Mother, Brother, Sister etc.)

☐ Prostate cancer_____ ☐ Breast cancer_____

☐ Bleeding disorder_____ ☐ Blood clots_____

☐ Kidney cancer_____ ☐ Kidney disease/failure_____

☐ High blood pressure_____ ☐ Lung disease_____

☐ Heart by-pass surgery_____ ☐ Heart Valve surgery_____

☐ Other family history not mentioned:_____
_____
_____

Review of Systems- Do you have any of the following symptoms or diseases?

Constitutional

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

Ears/nose/throat

Blurred vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Poor hearing	☐ Yes	☐ No
Difficulty speaking	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No

Cardiopulmonary

Chest pain	☐ Yes	☐ No
Irregular heart beat	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No
Tired/sluggish	☐ Yes	☐ No

Genitourinary

Urinary retention	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Urinary frequency	☐ Yes	☐ No
Sexual problems	☐ Yes	☐ No

Musculoskeletal

Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Leg/Arm weakness	☐ Yes	☐ No

Neurological

Tremors	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No

Hematologic/lymphatic

Swollen glands	☐ Yes	☐ No
Easy bleeding	☐ Yes	☐ No

Immunologic

Immune deficiency	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No

Psychological

Depression	☐ Yes	☐ No
Bipolar disorder	☐ Yes	☐ No

Exercise Tolerance

How many flights of stairs can you climb BEFORE you become short of breath?_____

Do you engage in a formal exercise program? Yes/No

If yes; what type?_____How many times/week?_____

OTHER

Have you had a cardiac stress test? ☐ Yes ☐ No; If yes, when?_____

What type?_____

Result?_____

Where was it done?_____

Information from: ❑ Patient ❑ Legally Authorized Person (LAP) ❑ Family ❑ Patient's Medication List ❑ EMS/Transport ❑ Physician Office

❑ Medication List from non-AdventHealth Orlando facility ❑ Prior AdventHealth Orlando record ❑ Other:

❑ _____

❑ **NO KNOWN CURRENT HOME MEDICATIONS**

CURRENT MEDICATIONS: Prescription / Over the counter / Vitamins / Herbals / Supplements / Neutraceuticals	**DOSE** Quantity, strength	**ROUTE** Oral, injectable, inhaler, topical	**FREQUENCY** # of times per day, every day (no abbreviations)	***HOSPITAL STAFF TO COMPLETE (Day of procedure)*** ***LAST DOSE: DATE / TIME***

Box(es) not completed for dose, route or frequency – information was not available. Should information become available – complete as applicable.

_____ _____ _____ _____

Hospital Authorized Staff – First Initial, Last Name, Title | Date / Time | Hospital Authorized Staff – First Initial, Last Name, Title | Date / Time

❑ **NO changes to listed medications** ❑ **Your physician has ordered changes to some of your listed home medications as indicated below**

***DISCHARGE: NEW MEDICATIONS and/or CHANGES TO PREVIOUS MEDICATIONS*:**

MEDICATION(S)	***DOSE***	***ROUTE***	***FREQUENCY***	***NEXT DOSE***	***Rx***	***INSTRUCTIONS***

This information was provided by you or your representative. If this information does not match your home records, or if you have any questions please contact the doctor that prescribed your medication(s).

_____ _____ _____

❑ **Patient** ❑ **Responsible Person Signature** | **Print Name / Relationship** | **Discharge: First Initial, Last Name, Title** **Date/Time**

Check if applicable: ❑ *Long term medication modified or added – updated list provided to Next Provider of Care*

AdventHealth Orlando

OUTPATIENT MEDICATION LIST

DH: Medication Reconciliation Document
602-1030 (02-09) (MPC# 72655)

White – chart Canary - Patient

Patient Label

Outpatient Personal Health History – Adult

General Information

Information Provided by (Relationship):

- ☐ Patient
- ☐ Other _____

Reason for Hospital Visit:

Health Care Surrogate or Next of Kin: Name: _____

Relationship: _____

Preferred Pharmacy Name/Phone#_____

Obstructive Sleep Apnea

Patient to Receive Sedation: ☐Yes ☐ No ***If "Yes", must complete Obstructive Sleep Apnea (OSA) Screen***

Have you been diagnosed with Obstructive Sleep Apnea (Confirmed by Sleep Study)? ☐Yes

Do you use a CPAP or BiPAP machine at home? ☐Yes (3) ☐No (3) ***If "Yes" OSA Risk Screen: Positive***
Did you bring it to the hospital? ☐Yes ☐No

Are you compliant with the use of your CPAP/BiPAP machine? ☐Compliant (regular use) ☐Non-compliant

Have you been diagnosed with Obstructive Sleep Apnea (Confirmed by Sleep Study)? ☐No

Stop-Bang Scoring Questionnaire

Snore:	Do you snore loud enough to be heard through closed doors?	☐Yes (1) ☐No (0)
Observed:	Have you been told you stop breathing during sleep?	☐Yes (1) ☐No (0)
BMI:	Is your Body Mass Index (BMI) more than 35 Kg/M2?	☐Yes (1) ☐No (0)
Tired:	Do you feel sleepy, fatigued or fall asleep easily during the day?	☐Yes (1) ☐No (0)
Pressure:	Do you have high blood pressure?	☐Yes (1) ☐No (0)
Neck	Is your neck size greater than 17 inch or do you wear XL shirt?	☐Yes (1) ☐No (0)
Age	Are you age 50 years or older?	☐Yes (1) ☐No (0)
Gender	Male?	☐Yes (1) ☐No (0)

Total Score_____

Total Score of 1-2 = OSA Risk Screen: Negative
Total Score of 3 or higher = OSA Risk Screen: Positive (Risk Screen Positive - enter Outpatient OSA Risk Protocol, Adult 959-3086B)

Allergies (Food, Drug, Environmental)

Allergy	Reaction	☐ No Known Allergies
_____	_____	
_____	_____	
_____	_____	

Patient Label

Medical History

Do you have any medical devices, pumps, patches in or on your body: ☐ Yes ☐ No

Type: _____

***If Meds delivered by pump/patch nurse to record on Medication History**

Medical: ☐ No past medical history

_____ Year_____
_____ Year_____
_____ Year_____
_____ Year_____

Surgical: ☐ No past surgical history

_____ Year_____
_____ Year_____
_____ Year_____
_____ Year_____

Family History: ☐ No past family history

Relationship_____ History of:_____Health Status_____
Relationship_____ History of:_____Health Status_____
Relationship_____ History of:_____Health Status_____

Social History

Tobacco:
Current Use:_____Type:_____Frequency/Years:_____Details_____
Alcohol:
Current Use:_____Type:_____Frequency:_____Details_____
Substance Abuse:
Current Use:_____Type:_____Frequency:_____Details_____
Employment/School:
Status:_____Details:_____
Exercise:
Duration:_____Type:_____Frequency:_____ Details_____
Home/Environment:
Lives with:_____Living Situation:_____Home Equipment:_____
Nutrition/Health:
Details:_____
Sexual:
Details:_____
Other:
Details:_____

PHH completed/reviewed by: _____ Date_____Time_____

Staff Name Printed: _____

Patient Label

Center for Urologic Cancer
FLORIDA HOSPITAL MEDICAL GROUP

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME:_____**TODAY'S DATE:**_____ **SURGERY DATE:**_____
(If applicable)

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. Choose 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 MONTH:

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**

DOB _____

Center for Urologic Cancer
FLORIDA HOSPITAL MEDICAL GROUP

AUA SYMPTOM SCORE

PATIENT NAME:_____ **TODAY'S DATE:**_____ **SURGERY DATE:**_____
(If applicable)

Check the number of the response that best describes your urinary function and write your score in the far right box for all SEVEN questions.

1. **Incomplete emptying**: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

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
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	

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

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
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	

3. **Intermittency**: Over the past month, how often have you found that you stopped and started again several times when you urinated?

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
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	

4. **Urgency**: Over the past month, how often have you found it difficult to postpone urination?

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
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	

5. **Weak-stream**: Over the past month, how often have you had a weak stream?

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
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	

6. **Straining**: Over the past month, how often have you had to push or strain to begin urination?

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
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	

7. **Nocturia**: Over the past month or so, how many times did you get up to urinate from the time you went to bed until you got up in the morning?

None	1 time	2 times	3 times	4 times	5 or more times	Your score
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	

Add up your scores for total AUA score=____

Quality of Life Due to Urinary Symptoms: 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? (Choose an answer)

Delighted ☐ Pleased ☐ Mostly satisfied ☐ Mixed ☐ Mostly dissatisfied ☐ Unhappy ☐ Terrible ☐

DOB _____