



Today's Date: \_\_\_\_\_

### PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

Patient's Last Name:	First Name:	Middle Name:
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal/former name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Date of birth:	Age:	SSN:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
<u>Race:</u> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Refuse to Report <input type="checkbox"/> Native Hawaiian		<u>Ethnicity:</u> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic /Latino <input type="checkbox"/> Other: _____
Preferred Language:		

### ADDRESSES HOME & WORK

Home Address:	City:	State	Zip code:
Home/Cell Phone Number:		Email:	
Employer Address:	City:	State:	Zip code:
Occupation/Position:	Employer/Business Phone Number:		

### HOW DID YOU HEAR ABOUT OUR CLINIC?

<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Hospital	<input type="checkbox"/> Online
<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Other
Where you referred to us by your doctor? <input type="checkbox"/> YES <input type="checkbox"/> No		
If yes, please write your doctor's name _____ and their phone number _____		
Primary Physician's Name:		
Phone Number:		

### INSURANCE INFORMATION

Define Coverage Type:		
<input type="checkbox"/> Self-Pay (no insurance)	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other Insured (spouse) <input type="checkbox"/> Workers Comp
Insurance carrier:	ID:	
Secondary Insurance carrier (if applicable):	ID:	
Other Person Responsible for my bill:		
Name:	Relationship to patient:	
Date of Birth:	Contact Phone Number:	

### IF A MINOR ONLY:

Fathers Name:	Mothers Name:
---------------	---------------

### IN CASE OF EMERGENCY

Name of local friend or relative (not living with you):	Relationship to patient:	Phone Number:
------------------------------------------------------------	--------------------------	---------------



## MEDICAL INFORMATION RELEASE FORM

This form is to allow Comprehensive Urology Medical Group, its physicians, and its staff to release the stated medical information to designated family and/or friends.

I, \_\_\_\_\_ hereby authorize Comprehensive Urology Group to provide information about my medical information to family or friends that I name in this document. Comprehensive Urology may release information relating to the items checked below.

Please list the persons allowed to receive information and your relationship.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Information to be released:

- ☐ Appointment information
- ☐ Lab results
- ☐ General health inquiry
- ☐ Surgery pre-op and post-op instructions
- ☐ Request copies of medical records
- ☐ Other \_\_\_\_\_

By checking the item(s) above, I acknowledge that I have authorized Comprehensive Urology Medical Group to release such information. I have read and reviewed the foregoing release and understand its contents.

I acknowledged that Comprehensive Urology Medical Group is hereby released from any all claims, demands, or liabilities arising out of or in any way related to the disclosure of the information above.

I also have the right to change or revoke this request at any time.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



**AUTHORIZATION TO PAY MEDICAL & SURGICAL BENEFITS  
DIRECTLY TO ATTENDING PHYSICIAN**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Comprehensive Medical Group (providers of service, including but not limited to; Drs. Dino Deconcini, Kia Michel, Alex Nourian, Jeannie Su, and/or Comprehensive Urology Medical Group) all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and lab's expenses.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and full understand this agreement.

---

Print Patient's Name

---

Patient's Signature

---

Date



## PATIENT CREDIT CARD ON FILE AGREEMENT

We have implemented a new billing policy which improves efficiency and minimizes the number of statements that are generated to you monthly. This policy enables you to retain your credit card information securely on file on an encrypted web-site. In providing us with your credit card information, you are giving Comprehensive Urology Medical Group permission to automatically charge your credit card on file for your co-pay [or any other patient(s) you have listed on this form] at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

**Co-pays:** Co-pays are due at time of the office visit.

**Outstanding Balance:** If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, we will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

**Multiple Users:** This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

*I authorize Comprehensive Urology Medical Group, to charge co-pays and outstanding balances on my account to the following credit card:*

- ☐ VISA
- ☐ MASTERCARD
- ☐ AMERICAN EXPRESS
- ☐ DISCOVER

Credit Card Holder's Name: \_\_\_\_\_

Last 4 digits of Credit Card: \_\_\_\_\_ Expiration Date: (MM/YYYY): \_\_\_\_/\_\_\_\_ CVC: \_\_\_\_\_

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: \_\_\_\_\_

Patient Full Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices.

Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice.

I, \_\_\_\_\_, have received a copy of this office's *Notice of Privacy Practices*.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please specify) \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES**  
**COMPREHENSIVE UROLOGY MEDICAL GROUP**

Effective January 1, 2005

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.** Please review it carefully. Our practice uses health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our practice.

**HOW OUR PRACTICE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION**

**For Treatment.** Our practice may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as physicians, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and not how you respond to these actions.

**For Payment.** Our practice may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

**For Health Care Operations.** Our practice may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to member of the medical staff, risk or quality improvement personnel, and others in order to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your case and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide

**Appointments.** Our practice may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Required by Law.** Our practice may use and disclose information about as required by law. For example, our practice may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

**Public Health.** Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

**Decedents.** Health information may be used to funeral directors or coroners to enable them to carry out their lawful duties.

**Organ/Tissue Donations.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.



**Research.** Our practice may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

**Health and Safety.** Your health information may be disclosed to avert a serious threat to health or safety of you or any other person pursuant to applicable law.

**Government Functions.** Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

**Worker's Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation.

**Other Uses.** Other uses and disclosures will be made only with your written authorization, and you may revoke the authorization except to the extent of our practice has taken action in reliance on such.

#### YOUR HEALTH INFORMATION RIGHTS

You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 C.F.R. 164.522; however, our practice is not required to agree to a requested restriction;
- obtain a paper copy of the notice of information practices upon request;
- inspect and obtain a copy of your health record as provided for in 45 C.F.R.164.524;
- request that your health record be amended as provided in 45 C.F.R. 164.526;
- request communications of your health information by alternative means or at alternative locations; and
- receive an accounting of disclosures made of your health information as provided by 45 C.F.R. 164.528.

#### COMPLAINTS

You may complain to our Privacy Officer and/or to the Department of Health and Human Services if you believe your privacy right have been violated. You will not be retaliated against for filing a complaint.

#### OBLIGATIONS OF OUR PRACTICE

Our practice is required by law to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed; and
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.
- notify you if a breach in the security of your Protected Health Information (PHI) occurs



Our practice reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by in-office handouts or via our website.

#### CONTACT INFORMATION

If you have any questions or complaints, please contact:

Privacy Officer: Lina Barricello





Name: \_\_\_\_\_

Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Welcome to our office or welcome back. We want to provide you with the best possible care, so please take a few moments to complete the following pages. Thank you.

**What is the main urologic issue you would like to discuss?**

---

---

---

**Do you have any other urologic issues you would like addressed?**

---

---

---

**Please list any medical conditions you have (high blood pressure, diabetes, etc.):**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Please list any prior surgeries or procedures:**

**Date of surgery/procedure:**

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

**Please list any current medications/herbal supplement:**

**Dose:**

- |           |       |
|-----------|-------|
| 1. _____  | _____ |
| 2. _____  | _____ |
| 3. _____  | _____ |
| 4. _____  | _____ |
| 5. _____  | _____ |
| 6. _____  | _____ |
| 7. _____  | _____ |
| 8. _____  | _____ |
| 9. _____  | _____ |
| 10. _____ | _____ |



Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Please list any medications you are allergic to:

Reaction:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any serious illness in your family:

Relative: \_\_\_\_\_

Illness: \_\_\_\_\_

Relative: \_\_\_\_\_

Illness: \_\_\_\_\_

Relative: \_\_\_\_\_

Illness: \_\_\_\_\_

**MALE PATIENTS ONLY:**

Do you have difficulty achieving or maintaining an erection?

Yes ☐ No ☐

Have you ever had an abnormal PSA result?

Yes ☐ No ☐

Have you ever had a prostate biopsy?

Yes ☐ No ☐

If yes, please list biopsy date(s) and result(s): \_\_\_\_\_

Ashkenazi Jewish Ancestry?

Yes ☐ No ☐

Have you or any one in your family been diagnosed with metastatic prostate cancer?

Yes ☐ No ☐

Have you or any one in your family been diagnosed with ovarian cancer?

Yes ☐ No ☐

Have you or any one in your family been diagnosed with pancreatic cancer?

Yes ☐ No ☐

Have you or any one in your family been diagnosed with breast cancer <50 years old?

Yes ☐ No ☐

Have you or any one in your family been diagnosed with any other type of cancer(s)? If yes, please indicate what type: \_\_\_\_\_

Yes ☐ No ☐

\*\*\*\*\*

Please indicate your current marital status:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

On average, how many alcoholic beverages do you have in a week? \_\_\_\_\_

Did you ever smoke on a regular basis? Yes ☐ No ☐

If yes, how many packs a day? For how many years? \_\_\_\_\_

Are you still smoking? Yes ☐ / No ☐ If no, when did you quit? \_\_\_\_\_

Have you had a colonoscopy in the last 5 years? Yes ☐ / No ☐

Do you have an Advanced Care Plan in place? Yes ☐ / No ☐ / No ☐ (my cultural and/or spiritual beliefs preclude me from having a discussion regarding advance care planning)

If yes... ☐ Living Will ☐ Do Not Resuscitate ☐ Power of Attorney



Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### REVIEW OF SYSTEMS

Do you or have you recently had any problems related to the following?

If your answer is Yes, please explain in the space provided.

	YES	NO		YES	NO
<b><u>Constitutional</u></b>			<b><u>Gastrointestinal</u></b>		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Other			Other		
<b><u>Eyes</u></b>			<b><u>Musculoskeletal/Neck</u></b>		
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain	<input type="checkbox"/>	<input type="checkbox"/>
Other			Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Ears/Nose/Throat</u></b>			Other		
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Neurological</u></b>		
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells (Lightheadedness)	<input type="checkbox"/>	<input type="checkbox"/>
Other			Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Respiratory</u></b>			Other		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Integumentary</u></b>		
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Other			Skin lesion(s)	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Cardiovascular</u></b>			Breast (lumps, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Other		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Allergic/Immunologic</u></b>		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Other			Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Genitourinary</u></b>			Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Other		
Wake to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Hematologic/Lymphatic</u></b>		
# of times			Blood clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>
Slow stream	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Push to urinate	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>
Retaining urine	<input type="checkbox"/>	<input type="checkbox"/>	Other		
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Endocrine</u></b>		
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Too hot/cold	<input type="checkbox"/>	<input type="checkbox"/>
# of pads per day			Tired/sluggish	<input type="checkbox"/>	<input type="checkbox"/>
Sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	Other		
Low libido	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>Psychological</u></b>		
Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty reaching orgasm	<input type="checkbox"/>	<input type="checkbox"/>	Other		
Other					

Physician Signature

Date

Last Name : \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

### URINARY SYMPTOM SCORE

From the scale 0 to 5, please select the box that best describes your response for each question and fill in your score in the far-right box for all SEVEN questions.

1. **Incomplete emptying:** Over the past months(s) how often have you had the 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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	

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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	

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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	

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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	

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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	

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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	

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 the time you got up in the morning?

Not at All	1 time	2 times	3 times	4 times	5 or more times	Your Score
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	

Add up your score 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? Please select your answer below.

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

Last Name : \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

### THE IIEF-5 QUESTIONNAIRE (SHIM)

Please select the box that best describes you for the following five questions.

**Over the past 6 months**

1. How do you rate your confidence that you could get and keep an erection?	<b>Very Low</b> <input type="checkbox"/> <b>1</b>	<b>Low</b> <input type="checkbox"/> <b>2</b>	<b>Moderate</b> <input type="checkbox"/> <b>3</b>	<b>High</b> <input type="checkbox"/> <b>4</b>	<b>Very High</b> <input type="checkbox"/> <b>5</b>
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	<b>Almost never or never</b> <input type="checkbox"/> <b>1</b>	<b>A few times (much less than half the time)</b> <input type="checkbox"/> <b>2</b>	<b>Sometimes (about half the time)</b> <input type="checkbox"/> <b>3</b>	<b>Most times (much more than half the time)</b> <input type="checkbox"/> <b>4</b>	<b>Almost always or always</b> <input type="checkbox"/> <b>5</b>
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	<b>Almost never or never</b> <input type="checkbox"/> <b>1</b>	<b>A few times (much less than half the time)</b> <input type="checkbox"/> <b>2</b>	<b>Sometimes (about half the time)</b> <input type="checkbox"/> <b>3</b>	<b>Most times (much more than half the time)</b> <input type="checkbox"/> <b>4</b>	<b>Almost always or always</b> <input type="checkbox"/> <b>5</b>
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	<b>Extremely difficult</b> <input type="checkbox"/> <b>1</b>	<b>Very difficult</b> <input type="checkbox"/> <b>2</b>	<b>Difficult</b> <input type="checkbox"/> <b>3</b>	<b>Slightly difficult</b> <input type="checkbox"/> <b>4</b>	<b>Not difficult</b> <input type="checkbox"/> <b>5</b>
5. When you attempted sexual intercourse, how often was it satisfactory for you?	<b>Almost never or never</b> <input type="checkbox"/> <b>1</b>	<b>A few times (much less than half the time)</b> <input type="checkbox"/> <b>2</b>	<b>Sometimes (about half the time)</b> <input type="checkbox"/> <b>3</b>	<b>Most times (much more than half the time)</b> <input type="checkbox"/> <b>4</b>	<b>Almost always or always</b> <input type="checkbox"/> <b>5</b>

**Total Score:** \_\_\_\_\_

1-7  
Severe ED

8-11  
Moderate ED

12-16  
Mild-moderate ED

17-21  
Mild ED

22-55  
No ED