MHM MEN'S HEALTH MELBOURNE

SPECIALISTS IN: UROLOGY | FERTILITY | ANDROLOGY

menshealthmelbourne.com.au

Welcome to Men's Health Melbourne. Our goal is to provide you with the best patient care experience.

Thank you for taking the time to fill in this patient questionnaire booklet.

There are 8 pages to this booklet – please ensure that you complete all pages that are relevant to you.

Please try be as detailed as possible as it will help the specialist to manage your care.

BEFORE you begin filling in this questionnaire:

- If you have brought ANY documentation with you (referrals, letters, test results) please give these to the front desk reception as the specialist will need to review these PRIOR to the consultation.
- If you have previously sent in any of this documentation, or you expected the documentation to have arrived at our clinic prior to this appointment, please check with the front desk reception that it is in your file.

Please feel free to email us feedback about any aspect of your patient care:
info@menshealthmelbourne.com.au

Regards,

The Team
Men's Health Melbourne

NEW PATIENT INFORMATION & CONSENT FORM

Title: Mr/Mrs/Ms/Miss First Name: _____ Surname: _____

Date of birth: _____ Age: _____ Sex: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Ph: _____ Work Ph: _____ Mobile:_____

Email address: _____ Occupation: _____

Partner/NOK Name: _____ Relationship: _____

Partner/NOK Contact No: _____

Medicare No.:_____ Reference no.: _____ Expiry date: _____

(If you're bank details are linked with Medicare, would you like our office to electronically claim the appt. for you? YES / NO)

Private Health Fund: _____ Membership no.: _____

Have you been in your private health fund for more than 12 months? Yes / No

Pension Card/Health Care Card no.: _____

DVA Card Number: _____ Gold Card: Yes / No

Referring Doctor: _____ Ph: _____

Address: _____

Usual G.P. (if different from above): _____Ph: _____

GP Address: _____

Are there any other doctor's you would like correspondence send to?

Name: _____ Ph: _____

Address: _____

TAC: Date of accident: _____/ _____/ _____ Claim no: _____

WORKCOVER: Injury date: _____/ _____/ _____ Claim no: _____

Insurance Company: _____ Case Manager: _____

Insurance Address: _____ Ph: _____

Employer: _____ Ph: _____

Address: _____

CONSENT TO COLLECT PATIENT INFORMATION

As a patient of Men's Health Melbourne, a medical record containing personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and the details of your referring doctors and doctors involved in your care. During the period of assessment and ongoing management, information of relevance is recorded in your clinical notes. These records are stored securely and may be kept for up to 7 years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available on request.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

- I understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any purpose other than the above, my consent will be sought.
- I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Please Note:

Patient's Name (Please print)	Patient's Signature	Date

FEES

In accordance with standard business practice, **payment is requested at the time of consultation.**
Please note payment is required on the day of appointment. Any outstanding invoice that require Debt collection will attract an additional 20% to cover costs incurred.

For eligible patients, a portion of your account will be claimable from Medicare.

There may be additional charges associated with your consultation for as recommended by your specialist. You may be referred for other tests by your specialist such as radiology or pathology, which may incur out of pocket costs. Information regarding fees and charges for these additional tests can be obtained from the provider you are referred to. Should you require an elective admission to hospital, you will be provided with a detailed quote and informed financial consent form prior to your admission.

How did you first hear about Men's Health Melbourne?

☐ GP recommendation ☐ Search Engine (Google etc) ☐ Word of Mouth ☐ Social Media

Have you visited menshealthmelbourne.com.au? Y/N
If yes, for what purpose?

PAST MEDICAL HISTORY

Presenting problem:

Please list the main concern you would like addressed today _____

Have you seen another urologist/specialist for this problem? Y/N

If so, approximately how long ago _____

Medications:

Do you have any Drug allergies? Y/N If Y, please state _____

Do you take any drugs to thin the blood (e.g. aspirin, warfarin, Plavix, Pradaxa etc)? Y/N

Please list your usual medications (dosages not required).

_____

_____

_____

Do you take fish oil? Y/N

Past Urological History:

Have you been previously been diagnosed with a urological problem? Y/N

If Yes – Please tick all relevant:

☐ Kidney (e,g, kidney stones, cancer etc), ☐ Bladder (e.g. UTI, cancer, etc)

☐ Prostate (e.g. enlarged, cancer etc) ☐ Testicle (e.g. infection, cancer etc)

☐ Penis (e.g. erectile dysfunction, Peyronies disease etc)

Please provide details (problem/dates/treatments). Please also note if have had any procedures on any of the above areas.

_____

_____

_____

_____

Have you ever had bleeding in the urine? Y/N

Have you every had any of the following operations:

Circumcision Y/N Date: _____

Vasectomy Y/N Date: _____

Hernia repair Y/N Side: Left/Right/Both Date: _____

Cystoscopy ("camera into the bladder") Y/N Date: _____ Reason: _____

Past procedures:

Please list ANY other operations/procedures you have had and the date of the operation
(even if it is not related to the problem you are seeking treatment for):

_____

_____

_____

_____

Medical conditions:

Please tick if you have been diagnosed with or told you have:

☐ Diabetes type 1/2 ☐ High blood pressure ☐ Bleeding tendency

☐ Deep Vein thrombosis ☐ Breathing/lung problems ☐ HIV/Hepatitis

☐ Cholesterol ☐ Depression/anxiety ☐ Cancer

☐ Problem with anaesthetics ☐ Any Neurological condition – stroke, Parkinson's, spinal problem

☐ Heart condition e.g. Heart attack, arrhythmia (e.g. AF) valve replacement, defibrillator

Please give details about the above condition(s) or list any other conditions:

_____

_____

_____

_____

_____

Family/Social History:

Do you have any significant Family History (e.g. cancer, kidney stones) _____

Do you/have you ever smoked? If Yes – how long for _____ If quit – how long ago _____

Alcohol – How many (if any) standard drinks do you consume per week? _____

Caffeinated beverages – How many (if any) caffeinated beverages do you consume per day? (coffee, tea, Coke, energy drinks) _____

Fluids – in total, how much fluid do you drink per day? _____

Please provide the specialist with any other information relevant to you condition and please write any questions that you would like answered?

_____

_____

_____

_____

If you have ANY urinary voiding symptoms, please complete pages 6 (IPSS)

If you have ANY erectile/sexual function concerns, please complete page 7 (SHIM)

If you have made an appointment to discuss any issue related to male fertility (incl. fertility checks, vasectomy/ vasectomy reversal, sperm problems), please complete page 8

Thank you once again for taking time to complete this questionnaire.

INTERNATIONAL PROSTATE SYMPTOM SCORE (IPSS)

If you have any problems or symptoms with your urination please fill in this questionnaire prior to seeing the specialist. This will help the specialist in your assessment and personalised management.

Name: _____ Date: _____

	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
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	1 time	2 times	3 times	4 times	5 times or more	YOUR SCORE
Nocturia How many times (per night) did you typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally satisfied & dissatis-fied	Mostly dissatis-fied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

Patients Name: _____ Today's Date: _____

What type (if any) of relationship are you in?

☐ Single ☐ Married ☐ Partnered ☐ Divorced

How do you rate your libido ?– Strong, Moderate, Weak.

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
	0	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 halfthe 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

MALE FERTILITY QUESTIONS:

Current Partner related questions:

1. How old is your current partner? _____
2. Does she have regular cycles? Y/N
3. Has she had any tests for evaluation of her fertility? Y/N
4. Has she been told that she has a condition that could affect her fertility? Y/N
5. Has your current partner ever had any pregnancies with another man?: Y/N

   If Yes, Please describe the date & outcome of these pregnancies: _____
6. Has she seen an IVF specialist? Y/N

   If Y, please give details of the specialist _____
7. Have she gone through IVF yet? Y/N

   If yes, how many cycles? _____

Vasectomy reversal patients do <u>not</u> need to answer any further questions. All other feritlity related patients, please complete the questionnaire.

8. How many months have you been trying to achieve pregnancy with your current partner? _____
9. Have you ever achieved a pregnancy with your partner in the past? Y/N

   If yes, please give date & outcome of pregnancies: _____
10. Have you ever achieved a pregnancy with another partner? Y/N

    If Yes, please give the date & outcome of these pregnancies _____
11. Have you ever had a semen analysis? Y/N

    If Y, please give dates (approx.) _____
12. Have you ever been told you have a sperm problem? Y/N
13. Have you had any blood tests/ultrasounds to investigate your infertility? Y/N
14. Have you ever had an STD? Y/N
15. Have you had any major childhood illnesses? Y/N
16. Have you had any problems with you testicles in the past? Y/N

    ☐ Trauma ☐ Undescended testicles as a child ☐ Surgery
17. Do you have any erection/libido problems? Y/N