

For nurse:

VITAL SIGNS

BP TEMP PULSE HT WT Taken By:



International prostate symptom score (IPSS)

| Name / Date of Birth _____ (Please complete in BLACK ink) | 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 | |

| | | | | | | | |
|--|---|---|---|---|---|---|--|
| Nocturia Over the past month, HOW MANY TIMES did you most 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 | |
|-------------------------|--|

| Quality of life due to urinary symptoms | Delighted | Pleased | Mostly Satisfied | Mixed- about equally satisfied and dissatisfied | Mostly dissatisfied | 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? Your Score | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

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

URINARY MEDICATIONS:

- | | | |
|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Flomax 0.4 mg caps | <input type="checkbox"/> Once a Day | <input type="checkbox"/> Twice a Day |
| <input type="checkbox"/> Rapaflo 8 mg caps | <input type="checkbox"/> Once a Day | |
| <input type="checkbox"/> Cardura (Doxazosin) | Dose: _____ | |

(MD ONLY) Cystitis: None / Mild / Moderate / Severe

Incontinence: None / Mild / Moderate / Severe

Name: _____ DOB: _____ Date: _____

SHIM Score

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 a 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 none | 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 none | 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 none | 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 |

6. Do you use a Prescription Drug/Physical Device to help you obtain an erection? Yes No

SCORE: _____

Add the numbers corresponding to questions 1-5. If your score is 21 or less, you may want to speak to your doctor.

(MD ONLY) Erectile Dysfunction: None / Mild / Moderate / Severe

Patient Name: _____ Date: _____

Rectal Function Assessment Score (RFAS)

Respond regarding your experience during the past week

(Please complete in BLACK ink)

1. Number of bowel movements per day:

- 0 – 1 BM per day
- 2 BMs per day
- 3 BMs per day
- 4 or more BMs per day

2. Consistency of stools:

- All stools formed
- Stools formed and loose
- Stools loose
- Watery stools

3. Urgency of stools:

- No urgency
- Somewhat urgent
- Urgent
- Very urgent

4. Abdominal discomfort:

- No discomfort
- Mild to moderate discomfort
- Somewhat severe discomfort
- Very severe discomfort

5. Hemorrhoidal discomfort:

- No discomfort
- Requires mild treatment (i.e. tucks, sitz baths)
- Requires topical medication (i.e. Prep H, etc.)
- Requires oral analgesics or narcotics for relief

6. Rectal bleeding:

- No rectal bleeding
- Blood on toilet paper: 1 time per week
- 2-3 times per week
- ≥ 4 times per week

7. Continence:

- Normal continence; able to control stool movements at all times
- Gas incontinence only; able to control stool movements but not gas
- Minor spotting or leakage of stool (up to coin size) about once per week
- Minor spotting or leakage of stool (up to coin size) more than once per week
- Significant leakage of stool (larger than coin size) about once per week
- Significant leakage of stool (larger than coin size) more than once per week

8. Nighttime bowel movements (total number of nights in last week that you had to get up from bed to have a bowel movement):

- 0
- 1
- 2
- 3
- 4
- More than 4

9. Completeness of evacuation:

- Complete evacuation (requires one movement to completely empty bowel or feel you're "all done")
- Occasional multiple evacuations (about once a week feel like you're not "all done" or it takes more than one movement to finish)
- Frequent multiple evacuations (more than once a week feel like you're not "all done" or it takes more than one movement to finish)
- Requires enema to obtain complete emptying

10. Have you ever been diagnosed with Crohn's disease or ulcerative colitis? Yes No

(MD ONLY) Proctitis: None / Mild / Moderate / Severe