METROVAN UROLOGY
metrovanurology.com
#650 – 6091 Gilbert Road
Richmond, B.C. V7C 5L9
Tel: **604 273 4320** (24 hrs)
Fax: 604 273 7599

Previsit Questionnaire

PLEASE PRINT ONLY

Patient's Legal Name: _____
LAST NAME (LEGAL) GIVEN NAMES (LEGAL) PREVIOUS SURNAME(S)

Personal Health Care Number: _____ **Sex:** ☐ Male ☐ Female

Birthdate: Day _____ Month _____Year _____ Marital Status: _____

Your Present Address: _____

City: _____ Province: _____ Postal Code: _____

Which Month & Year Did You Move to the Above Address? _____

Previous Address (if less than 12 months at present address): _____

City: _____ Province: _____ Postal Code: _____

Which Month & Year Did You Move to This Address? _____

Present Employer: _____ Occupation _____

Since: Month _____ Year _____

Next of Kin: Name _____ Relationship _____
LAST NAME GIVEN NAME

Telephone: Please check the best number to contact you at.

(Home) ☐ _____ (Work) ☐ _____

(Cell) ☐ _____ (Other) ☐ _____

Is it OK to contact you on your cell phone? ☐ Yes ☐ No

Is it OK to contact you by email? ☐ Yes ☐ No

(Email): _____

USE OF EMAIL IS RESTRICTED TO SCHEDULING APPOINTMENTS. Please note that no confidential information such as results will be sent by email. We will NOT respond to email with medical questions.

This section only applicable if you are admitted for surgery

Accommodation Preferred (subject to availability only): ☐ Private Room ☐ Semi-Private Room ☐ Standard Ward

There is a Charge for Semi & Private Rooms – Payable on Discharge

Have You Ever Been a Patient in The Richmond Hospital: ☐ No ☐ Yes – when? _____

Urologist: _____ Family Physician: _____

Were You Born in B.C.? ☐ Yes ☐ No **If not, date of arrival in B.C.:** _____

Canadian Citizen? _____ **Landed Immigrant?** _____ **If Landed Immigrant and Have Lived in Canada Less than 1 Year, Photocopy of Immigration Papers Must be Provided Upon Admission.**

Thank you for completing this questionnaire. Email, Print, Fax or Bring to your appointment.

Richmond Hospital
part of the Vancouver Coastal Health Authority

PCIS LABEL

Surgeon:_____

Patient Name:_____ Sex:_____ Date of Birth:_____

Weight:_____lbs./kgs. Height:_____in./cm.

Check [✓] the correct column after each question. PLEASE COMPLETE BOTH SIDES OF THE PAGE.

	Yes	No	Not sure		Yes	No	Not sure
Do you currently have or do you have a history of:				Do you currently have or do you have a history of:			
1. Heart pain / angina				22. Kidney problems / failure			
2. Heart attack				23. Heartburn / hiatus hernia			
3. Heart murmur / heart valve problem				24. Liver disease / jaundice / hepatitis			
4. Stroke				25. Thyroid problems			
5. High blood pressure				26. Arthritis			
6. Irregular pulse				27. Bleeding disorders - yourself			
7. Circulation problems				- other family members			
8. Asthma / bronchitis / emphysema				28. Paralysis / weakness			
9. Shortness of breath with daily activity				29. Numbness of face or limbs			
10. New cough or cold				30. Seizures			
11. Chronic cough				31. Tumors / malignancy			
12. Sleep apnea or use a CPAP machine				32. Previous blood transfusion reactions			
Do you take:				33. Diabetes			
13. Pills for high blood pressure				- If **YES**, circle your treatment: diet only; insulin; pills			
14. Pills to thin your blood				34. Are you, or could you be, pregnant?			
15. Antibiotics before dental work				35. Do you have any other medical problems?			
16. Cortisone-like pills within last 6 months				Do you have:			
Do you:				Dentures	Upper		Lower
17. Smoke tobacco? How much?				Partial plate / dentures	Upper		Lower
18. Have you quit? When?				Capped / loose teeth			
19. Drink alcohol regularly? How much?				Hearing difficulties			
20. Take street drugs? What?				Hearing aid	Right		Left
21. Have you or any member of your family had any problems with anesthetics?				Glasses / contact lens / lens implant / prosthetic eye	Right		Left
Indicate who:							

If **YES** to any of the above questions, please explain: _____

_____

_____

_____

_____

Please turn over and complete Page 2 ➡

Do you have any allergies? Yes ☐ No ☐

Allergy to	Allergic Reaction

Please list all the medications and herbal supplements you take (use a separate piece of paper if you need more space):

Medication / Supplement Name	Dose (amount taken each time)	How often do you take it?	Reason for taking

List any operations you have had:

Date: Operation:

Is there anything else you want us to know about you?

Completed by (please print name): _____ **Date:** _____

If you are not the patient, what is your relationship to the patient? _____

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LAST Name (REQUIRED) FIRST Name (REQUIRED) DATE

How have your urinary symptoms been OVER THE PAST MONTH OR SO?

CIRCLE ONE NUMBER ON EACH LINE	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
1. Incomplete Emptying How often have you had a sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
2. Frequency How often have you had to urinate again less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
3. Intermittency How often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
4. Urgency How often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
5. Weak Stream How often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
6. Straining How often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**
7. Nocturia How many times per night 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?	**0**	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**≥ 5 Times**

QUALITY OF LIFE	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

How long have you had urinary symptoms?	How much coffee/tea/cola do you drink daily?
☐ Days ☐ Weeks ☐ Months ☐ Years	☐ None ☐ 1-2 ☐ 3-4 ☐ ≥ 5

Do you have any of the following: Check [√]	Yes	No	Not Sure	**Have you ever had any of the following:**	Yes	No	Not Sure
Burning with urination				Kidney stones			
Blood in the urine				Bladder/kidney infection			
Leakage of urine (incontinence)				Surgery on urinary tract			
Use of pads or diapers				Vasectomy			
Constipation				Brother or father with prostate cancer			

PLEASE ENSURE YOU HAVE COMPLETED ALL PAGES

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Sexual Function Questionnaire *(IIEF-5/SHIM)*

Instructions: These questions ask about the effects your erection problems have had on your sex life, **OVER THE PAST 6 MONTHS**. Please answer the following questions as honestly and clearly as possible. We understand the sensitive nature of these questions; therefore, all information is strictly confidential.

Mark ONLY one circle per question:

1. Over the past 6 months, how do you rate your confidence that you could keep an erection?

   ○ 1 Very Low
   ○ 2 Low
   ○ 3 Moderate
   ○ 4 High
   ○ 5 Very high

2. *Over the past 6 months*, when you had erections with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)?

   ○ 1 Almost never or never
   ○ 2 A few times (much less than half the time)
   ○ 3 Sometimes (about half the time)
   ○ 4 Most times (much more than half the time)
   ○ 5 Almost always or always

3. *Over the past 6 months*, during sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

   ○ 1 Almost never or never
   ○ 2 A few times (much less than half the time)
   ○ 3 Sometimes (about half the time)
   ○ 4 Most times (much more than half the time)
   ○ 5 Almost always or always

4. *Over the past 6 months*, during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

   ○ 1 Extremely difficult
   ○ 2 Very difficult
   ○ 3 Difficult
   ○ 4 Slightly difficult
   ○ 5 Not difficult

5. *Over the past 6 months*, when you attempted sexual intercourse how often was it satisfactory for you?

   ○ 1 Almost never or never
   ○ 2 A few times (much less than half the time)
   ○ 3 Sometimes (about half the time)
   ○ 4 Most times (much more than half the time)
   ○ 5 Almost always or always

5-7 Severe; 8-11 Mod; 12-16 Mild-Mod 17-21; Mild 22-25 None

6. Have you ever tried any of these medications?

   ○ Viagra ○ Cialis ○ Levitra ○ Staxyn

7. Do you have any problems with ejaculation?

   ○ Yes ○ No

8. How important is sexual function to you?

   ○ Low ○ Medium ○ High