

**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.



# 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 <b>YES</b> , 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? \_\_\_\_\_

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
<b>1. Incomplete Emptying</b> How often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
<b>2. Frequency</b> How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
<b>3. Intermittency</b> How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
<b>4. Urgency</b> How often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>5. Weak Stream</b> How often have you had a weak urinary stream?	0	1	2	3	4	5
<b>6. Straining</b> How often have you had to push or strain to begin urination?	0	1	2	3	4	5
<b>7. Nocturia</b> 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? <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	How much coffee/tea/cola do you drink daily? <input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> ≥ 5
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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				Immediate family with prostate or breast cancer			

**\*\*PLEASE ENSURE YOU HAVE COMPLETED ALL PAGES\*\***

## **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.

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

Have you ever used any of these medications?

- Viagra  Cialis  Levitra  Staxyn  No

Do you have any problems with ejaculation?

- Yes  No

How important is sexual function to you?

- Low  Medium  High