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 doctors 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 your 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: ____________

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not at all</th>
<th>Less than 1 time in 5</th>
<th>Less than half the time</th>
<th>About half the time</th>
<th>More than half the time</th>
<th>Almost always</th>
<th>YOUR SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incomplete emptying</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had to urinate again less than two hours after you finished urinating?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Intermittency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you found you stopped and started again several times when you urinated?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Urgency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the last month, how difficult have you found it to postpone urination?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Weak stream</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had a weak urinary stream?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Straining</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over the past month, how often have you had to push or strain to begin urination?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom</th>
<th>None</th>
<th>1 time</th>
<th>2 times</th>
<th>3 times</th>
<th>4 times</th>
<th>5 times or more</th>
<th>YOUR SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nocturia</strong></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**Total IPSS score**

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

<table>
<thead>
<tr>
<th>Quality of life due to urinary symptoms</th>
<th>Delighted</th>
<th>Pleased</th>
<th>Mostly satisfied</th>
<th>Mixed – about equally satisfied &amp; dissatisfied</th>
<th>Mostly dissatisfied</th>
<th>Unhappy</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

Patients Name: ____________________________ Today’s Date: _______

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

☐ Single   ☐ Married   ☐ Partnered   ☐ Divorced


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:

<table>
<thead>
<tr>
<th>Question</th>
<th>Very Low</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How do you rate your confidence that you could get and keep an erection?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0         1         2         3         4         5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?</td>
<td>No Sexual Activity</td>
<td>Almost Never Or Never</td>
<td>A Few Times (much less than half the time)</td>
<td>Sometimes (about half the time)</td>
<td>Most Times (much more than half the time)</td>
</tr>
<tr>
<td>0         1         2         3         4         5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?</td>
<td>Did Not Attempt Intercourse</td>
<td>Almost Never Or Never</td>
<td>A Few Times (much less than half the time)</td>
<td>Sometimes (about half the time)</td>
<td>Most Times (much more than half the time)</td>
</tr>
<tr>
<td>0         1         2         3         4         5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?</td>
<td>Did Not Attempt Intercourse</td>
<td>Extremely Difficult</td>
<td>Very Difficult</td>
<td>Difficult</td>
<td>Slightly Difficult</td>
</tr>
<tr>
<td>0         1         2         3         4         5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. When you attempted sexual intercourse, how often was it satisfactory for you?</td>
<td>Did Not Attempt Intercourse</td>
<td>Almost Never Or Never</td>
<td>A Few Times (much less than half the time)</td>
<td>Sometimes (about half the time)</td>
<td>Most Times (much more than half the time)</td>
</tr>
<tr>
<td>0         1         2         3         4         5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 not need to answer any further questions. All other fertility 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