

San Diego Sexual Medicine
PATIENT REGISTRATION

Your paperwork must be completed before your appointment.

Patient Name _____ Sex _____ Date _____

Social Security Number _____ - _____ - _____ Birth Date _____ Partner's Name _____

Single ___ In a Relationship ___ Co-habiting ___ Married/Domestic Partnership ___ Divorced/Separated ___ Other _____

Mailing Address: _____

Phone(s) (H) _____ (W) _____ (C) _____

Preferred phone: H / W / C E-mail address _____

I prefer that messages be given by: phone e-mail mail

Occupation _____ Employer _____

Highest level of Education _____ Race _____ Ethnicity _____

Name of Emergency Contact _____

First Middle Last

Relationship to Patient _____ Phone(s) _____

Referred by _____ Phone _____ Fax _____

Address _____

Please do not share my contact information with The Institute for Sexual Medicine, Inc.

CONDITIONS OF REGISTRATION

IMPORTANT, PLEASE NOTE: If the patient is incompetent, a legal guardian or conservator must sign.

MEDICAL CONSENT: The undersigned consents to medical examination, treatment, laboratory procedures and x-ray studies ordered by physician(s)/provider(s).

RELEASE OF INFORMATION: If you are found to have a condition that must be reported to a county, state or national health agency, your diagnosis will be reported as required by law to the appropriate agency. IF YOU HAVE BEEN REFERRED BY A HEALTHCARE PROVIDER A CONSULT REPORT WILL BE SENT TO THAT PROVIDER UNLESS OTHERWISE INDICATED.

FINANCIAL AGREEMENT: All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law, I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE SAN DIEGO SEXUAL MEDICINE, APC AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. SDSM may check and/or verify all patient's/responsible party's reference and financial information.

AUTHORIZATION TO TRANSFER FUNDS: Should a credit balance appear on the patient's account with SDSM during the course of care for the patient, the patient/responsible party authorizes use of the credit balance to pay any unpaid balance on any other accounts.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

The undersigned certify they have read the foregoing, received a copy thereof, and accept its terms.

Patient or Patient's Agent, Representative or Responsible Party Date

I personally guarantee the financial obligation indicated by the financial terms set forth above.

Co-signer/Responsible Party Date

Witness Date

San Diego Sexual Medicine
Director: Irwin Goldstein, MD
5555 Reservoir Drive, Suite 300
San Diego, CA 92120
P: 619.265.8865 F: 619.265.7696

CONSENT

PLEASE READ AND SIGN THE FOLLOWING:

We often get inquiries from family members and friends about the status of our patients. Please be advised that due to Federal Law, we will not release any information about our patients without their written consent. Please indicate below how you would like to disclose your information.

_____ Do NOT release any information to anyone other than myself.

_____ You may release information ONLY to the following person(s):

Name Relationship to Patient Phone Number

Name Relationship to Patient Phone Number

Name Relationship to Patient Phone Number

Name Relationship to Patient Phone Number

Signature Date

San Diego Sexual Medicine

AUTHORIZATION FOR RELEASE OF RECORDS

To: San Diego Sexual Medicine
5555 Reservoir Drive, Suite 300
San Diego, CA 92120
Phone: 619 265-8865
Fax: 619 265-7696

Irwin Goldstein, MD
Catherine Gagnon, CNP
Julea Minton, CNP

Patient's Name:

Address:

Phone:

Date of Birth:

I hereby authorize the release of my medical records, which should include date range _____ to _____

I request that these records be sent to:

Name:

Address:

Phone:

Fax:

I understand that by signing this authorization:

- I authorize the use or disclosure of my identifiable health information as described above.
- I have the right to withdraw permission for the release of my information. The revocation must be in writing and will not affect information already used or disclosed.
- I am signing this authorization voluntarily and treatment or payment will not be affected if I do not sign.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information without further authorization from me.

Signature

Date: _____

Name _____ Date _____

I found out about Dr. Goldstein and/or San Diego Sexual Medicine from:

- Referral
- The internet
- Television/radio _____
- A newspaper/magazine _____
- A book _____

I was referred to:

- Dr. Irwin Goldstein
- Sexual Medicine at Alvarado Hospital
- San Diego Sexual Medicine

I was referred by:

- My primary care physician
- A physician specializing in _____
- A friend or relative
- Self-referral

I would like Dr. Goldstein to send detailed information regarding my visit to myself.

- Yes No

Referring physician:

Name: _____ Phone: _____

Address: _____

I would like Dr. Goldstein to send detailed information regarding my visit to my referring physician.

- Yes No

Signature _____ Date _____

San Diego Sexual Medicine

MEDICAL HISTORY - PART I

Name _____ Date _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____

Married _____ yrs Monogamous _____ yrs Divorced Single Widowed

Major childhood illnesses: _____

Medications: _____

Drug allergies: _____

Food allergies _____ Latex allergy: _____

Have you ever had any of the following medical conditions? *(Check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neurologic disease (e.g. MS) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Genital conditions _____ |

Family history of any of the above conditions:

- | | |
|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Neurologic disease (e.g. MS) |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Urinary tract disease | <input type="checkbox"/> Incontinence |

Cancer: Type _____ Treatments: _____

Previous surgeries: Type and Date _____

Other medical disorders: _____

Depression Other psychological disorders: _____

Current smoker? Y / N _____ yrs Have you ever smoked? Y / N _____ packs/day

Do you ever drink alcohol? Y / N _____ drinks/day Do you eat/drink food with caffeine? Y / N _____

Do you use any recreational drugs (marijuana, cocaine, heroin, etc.): Y / N _____

Please describe: _____

Military service Criminal history _____

Have you ever had any of the following medical conditions? *(Check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Genitourinary conditions | <input type="checkbox"/> Interstitial cystitis |
| <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Cervical dysplasia |
| <input type="checkbox"/> Abnormal vaginal or urethral discharge | <input type="checkbox"/> Perineal trauma |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Yeast infections | <input type="checkbox"/> Vestibular adenitis |
| <input type="checkbox"/> Ovarian conditions | <input type="checkbox"/> Breast conditions |

San Diego Sexual Medicine

MEDICAL HISTORY - PART II

Name _____ Date _____

Age of first menstruation: _____ Are menses regular? Y / N
Pain with menstruation? Y / N Length cycle in days: _____
No. of pregnancies: _____ Dates: _____
Deliveries: Vaginal _____ Cesarean _____ Miscarriage: _____ Abortion: _____ Episiotomy? Y / N

Biologic children (your age/other parent): _____

Stillbirths / abortions (your age/other parent): _____

Hysterectomy: Y / N Date _____ Oophorectomy: Y / N Date _____

Treated for infertility? Y / N Date _____

Current contraceptive method: _____

Have you EVER used: birth control pill? Age at onset _____ Total years used _____
 birth control patch? Age at onset _____ Total years used _____
 birth control ring? Age at onset _____ Total years used _____

Do you have regular pap smears? Y / N Do you have regular breast exams? Y / N

If you are menopausal, age of menopause: _____ Are you on hormone therapy? Y / N

Type: _____ For how long? _____

Type: _____ For how long? _____

Type: _____ For how long? _____

Type: _____ For how long? _____

San Diego Sexual Medicine
SEXUAL HISTORY – PART I

Name _____ Date _____ Preferred Pronoun _____

Describe your sexual problem(s): _____

Present intercourse success rate: _____% Frequency of intercourse: _____

Age range at peak sexual function: _____

Rate your sexual function at peak function _____ at present 0-100% _____

Desire/interest _____

Lubrication/Arousal _____

Orgasm _____

Sexual/genital pain? Yes / No _____ Years: _____

Location: _____

Description: _____

Triggered by: _____

Made worse by: _____

Made better by: _____

To what do you attribute your sexual dysfunction? *Circle call that apply:*

Injuries _____ Childbirth _____ Surgery _____ Sexual Abuse _____

Medications: _____

Other: _____

Have you ever fallen on your crotch on a hard object?(bicycle bar, fence) _____ Yes / No _____

Please explain: _____

Are you a bike rider? Yes / No _____ Are you a horse rider? Yes / No _____

How long/often: _____ How long/often: _____

Previous diagnostic tests for your sexual problem: _____

Previous psychologic treatments for your sexual problem: _____

Previous medical treatments for your sexual problem: _____

Have a sexual partner? Yes / No _____ Does partner have sexual problems? Yes / No _____

Please explain: _____

San Diego Sexual Medicine
SEXUAL HISTORY – PART II

Name _____ Date _____

Previous jobs _____

Last worked _____ Ever on disability No Yes

Currently in a sexual relationship No Yes Sexual activities do you engage in with this partner:

Childhood religion _____ Current religion _____

Sexual History

Age when sexually active: _____ Oral sex _____ Intercourse _____

How often do you currently engage in sexual activity _____ week month

How often would you like to engage in sexual activity _____ week month

Who initiates: You Your partner Both

Menopausal No Yes Hormone therapy No Yes

Did you have sex education No Yes Where _____ By whom _____

Have you ever had an orgasm No Yes

Do you currently experience orgasm with your partner No Yes

Do you experience orgasm during masturbation No Yes

Did you ever have sexual fantasies No Yes Age began _____ Do you now No Yes

Did you ever masturbate No Yes Age began _____ Do you now No Yes

Do you know what stimulation you enjoy No Yes

Please check all that apply:

Heterosexual Bisexual Lesbian Gay Questioning Transgender

How do you feel about your sexual orientation? _____

Do you perform repetitive behaviors/mental acts to reduce anxiety No Yes

Please explain _____

Anything in your house that you must check frequently No Yes

Please explain _____

Are you especially concerned about safety No Yes

Please explain _____

History of treatment or problematic use:

Tobacco No Yes

Alcohol No Yes

Caffeine No Yes

Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Sleep disruption |
| <input type="checkbox"/> Diminished interest | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Significant weight loss or gain | <input type="checkbox"/> Diminished ability to concentrate |
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Change in motivation |
| <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Tearfulness |
| <input type="checkbox"/> Expansive mood lasting a week or longer with | |
| <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Shopping sprees |
| <input type="checkbox"/> More talkative | <input type="checkbox"/> Sexual indiscretions |
| <input type="checkbox"/> Flight of ideas | <input type="checkbox"/> Foolish business investment |
| <input type="checkbox"/> Distractibility | |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Trembling | <input type="checkbox"/> Chills or hot flashes |
| <input type="checkbox"/> Sensations of shortness of breath | <input type="checkbox"/> Excessive worries |
| <input type="checkbox"/> Feeling of choking | <input type="checkbox"/> Difficulty controlling worries |
| <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Nausea or abdominal distress | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Feeling dizzy or unsteady | <input type="checkbox"/> Difficulty concentration |
| <input type="checkbox"/> Feelings of being detached from self | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Muscle tension |
| <input type="checkbox"/> Numbness or tingling sensations | <input type="checkbox"/> Sleep disturbance |

San Diego Sexual Medicine

Director: Irwin Goldstein, MD
5555 Reservoir Drive, Suite 300
San Diego, CA 92120
P: 619.265.8865 F: 619.265.7696

In an effort to be more efficient as your sexual healthcare provider, we are moving our prescribing methods to e-prescribing wherever possible. Please help us by indicating your preferred pharmacy and their contact details:

Pharmacy name: _____

Address: _____

Phone: _____ Fax: _____