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-habitating ☐ Married/Domestic Parnership ☐ Divorced/Separated ☐ Other_____

Address: _____City, State, Zip: _____

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

Preferred phone: ◯ H ◯ W ◯ C E-mail:

I prefer that messages be sent 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: 619.265.7695

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 persons:

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, FNP-BC
Julea Minton, NP-C
Helen Stearns, DNP, APRN, FNP-BC
Maria Uloko, MD

Patient's Full Name: _____

Complete 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.

_____ Date: _____

Signature

San Diego Sexual Medicine

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
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: _____

MEDICAL HISTORY - PART I

(Please answer appropriate sections)

Name ______________________________ Date ______________________

Gender at birth _______ Gender identity _______ Preferred pronouns ______________________

Major childhood illnesses: ____

Medications (dosage): ____

____

____

Drug allergies: ______________________ Reaction: ______________________

Latex allergy: ______________________ Reaction: ______________________

Food allergies ______________________ Reaction: ______________________

Other allergies ______________________ Reaction: ______________________

Have you ever had any of the following medical conditions? *(Check all that apply)* ☐ None of these

☐ Migraines ☐ aura ☐ no aura
☐ Hypertension
☐ High Cholesterol
☐ Heart Disease
☐ Stroke/DVT/Blood clot in lungs
☐ Breast conditions ______________
☐ Prolapse ☐ uterine ☐ rectal ☐ vaginal
☐ Kidney disease
☐ Incontinence
☐ Interstitial cystitis
☐ Liver disease
☐ Chronic urinary tract infections (>3/yr)
☐ DES (Diethylstilbestrol)
☐ Abnormal Pap treatment date ______________
☐ Scrotal conditions
☐ Prostate conditions
☐ Chronic vaginal infections (>3/yr)
☐ Endometriosis
☐ PCOS
☐ Testicular conditions
☐ Epididymal conditions
☐ Thyroid problems ☐ hyper ☐ hypo
☐ Diabetes
☐ Osteoporosis ☐ Osteopenia
☐ Sexually transmitted disease ______________
☐ Seizure disorder
☐ Neurologic disease (e.g. MS)
☐ Suicide attempt
☐ Depression
☐ Bleeding disorder______________________
☐ Anxiety
☐ Other psychological disorders ______________
☐ Cancer: Type______________ Treatments: ______________________________________
☐ Trauma ☐ Perineal ☐ Genital
☐ Other medical disorders ____

Family history of any of the above conditions? *(Check all that apply)* ☐ None of these

☐ *Hypertension*
☐ *Heart Disease*
☐ *Stroke*
☐ *High Cholesterol*
☐ *Blood/clotting disorder*
☐ *Thyroid problems*
☐ *Diabetes*
☐ *Neurologic disease (e.g. MS)*
☐ *Asthma*
☐ *Cancer (other than basal cell)*

- -

Do you eat/drink food with caffeine? No ☐ Yes ☐ ____________

Current smoker? No ☐ Yes ☐ _____ yrs Have you ever smoked? No ☐ Yes ☐ ____ packs/day

Do you ever drink alcohol? No ☐ Yes ☐ _____ drinks/day

Do you use any recreational drugs (marijuana, cocaine, heroin, etc.): No ☐ Yes ☐

Please describe: ____

Criminal history No ☐ Yes ☐ ______________________________________

Military service No ☐ Yes ☐

☐ Single ☐ Married _____ yrs ☐ Lives with significant other _____ yrs ☐ Monogamous _____ yrs

☐ Divorced __ Widowed __ Not sexually active in monogamous relationship _____ yrs

☐ Other __________________ Age: _____ Height: _______ Weight:______

MEDICAL HISTORY - PART II

(Please answer appropriate sections)

Name _____ Date_____

Current contraceptive method: _____

Have you EVER used contraception:

Type: _____Age of onset: _____ For how long?_____

Type: _____Age of onset: _____ For how long?_____

Type: _____Age of onset: _____ For how long?_____

Dates: _____

Deliveries: Vaginal ____ Cesarean ____ No. of pregnancies:____ Miscarriage: _____ Abortion: ____

Biologic children ____ Stillbirths ____ Infertility Treatment ☐ Yes ☐ No Date _____

Living children (your age/other parent): _____

_____

_____

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

_____

Age of first menstruation: _____ Are menses regular? ◯ Yes ◯ No

Pain with menstruation? ◯ Yes ◯ No Length period in days: _____ Length cycle in days: _____

If you are menopausal, age of menopause: _____ Are you on hormone therapy? ◯ Yes ◯ No

Type: _____ For how long?_____

Type: _____ For how long?_____

Type: _____ For how long?_____

Type: _____ For how long?_____

Breast exams self-exam recently? ☐ Yes ☐ No Do you have regular pap smears? ☐ Yes ☐ No

Date of last pap smear _____ Date of last mammogram _____

Past Sexual Treatments *(Check all that apply)*

Diet	☐ Yes	☐ No	Vyleesi	☐ Yes	☐ No
Regular exercise	☐ Yes	☐ No	Adderall	☐ Yes	☐ No
Medication changed	☐ Yes	☐ No	Wellbutrin, cabergaline, ropinerole	☐ Yes	☐ No
Pelvic floor PT	☐ Yes	☐ No	MonaLisa/Laser Treatment	☐ Yes	☐ No
Vibrator to orgasm	☐ Yes	☐ No	Radiofrequency RF Therapy	☐ Yes	☐ No
Sex Therapy	☐ Yes	☐ No	Vacuum erection device	☐ Yes	☐ No
Counseling	☐ Yes	☐ No	MUSE	☐ Yes	☐ No
CBT	☐ Yes	☐ No	Intracavernosal injections	☐ Yes	☐ No
Psychiatric therapy	☐ Yes	☐ No	Penile prosthesis	☐ Yes	☐ No
Cialis, Levitra, Stendra Viagra	☐ Yes	☐ No	Penile revascularization	☐ Yes	☐ No
			Peyronie's curvature correction	☐ Yes	☐ No
Testosterone	☐ Yes	☐ No	Shockwave	☐ Yes	☐ No
Clomiphene citrate	☐ Yes	☐ No	Stem Cell Treatment	☐ Yes	☐ No
Arimidex	☐ Yes	☐ No	PRP	☐ Yes	☐ No
Addyi	☐ Yes	☐ No	Other _____		

Hysterectomy ☐ Yes ☐ No Date _____
Oophorectomy ☐ Yes ☐ No Date _____
Episiotomy ☐ Yes ☐ No
Vasectomy ☐ Yes ☐ No Date _____
Prostatectomy ☐ Yes ☐ No Date _____

Previous surgery Type and Date _____

Previous surgery Type and Date _____

Previous surgery Type and Date _____

Previous surgery Type and Date _____

SEXUAL HISTORY – PART I

(Please answer appropriate sections)

Name _____ Date_____ Preferred Pronoun _____

Describe your sexual problem(s): _____

_____

_____

Present intercourse success rate: _____% Frequency of intercourse: _____ week/month

Age range at peak sexual function: _____

Rate your sexual function	at peak function years old	at present 0-100%
Desire/interest	_____	_____
Lubrication/Arousal/Erection	_____	_____
Orgasm/Ejaculation	_____	_____

Sexual/genital pain? ◯Yes ◯No Years:

Location: _____

Description:_____

Triggered by: _____

Made worse by: _____

Made better by: _____

Genital numbness? ◯Yes ◯No Years: _____

Location: _____

Description:_____

Triggered by: _____

Made worse by: _____

Made better by: _____

To what do you attribute your sexual dysfunction? *Check all 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: _____

_____

Had penile trauma in erect state (crack sound during partner superior intercourse)? ◯Yes ◯No

Describe _____

Are you a bike rider? ◯Yes ◯No Are you a horse rider? ◯Yes ◯No

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

Please choose the number that best describes **the most frequent condition** of your penis during sexual activity over the last four weeks:

◯1. Penis is larger but not hard

◯2. Penis is hard but not hard enough for penetration

◯3. Penis is hard enough for penetration but not completely hard

◯4. Penis is completely hard and fully rigid

Nocturnal Emissions? ◯Yes ◯No Age of onset _____
Rate current sexual function compared to peak sexual function:
penile rigidity _____% sustaining capability _____% spontaneity _____%
Compared to peak sexual function morning erections are present/absent rigidity _____%
Ejaculation: normal _____ early _____ delayed _____
Approximate time from average penetration to ejaculation: _____ minutes
Is your erect penis curved? ◯Yes ◯No Direction: _____ Angle: _____
Does this affect your ability to have intercourse? ◯Yes ◯No Cause pain to your partner? ◯Yes ◯No

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: _____

_____

_____

SEXUAL HISTORY – PART II

(Please answer appropriate sections)

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

Testosterone deprivation ◯No ◯Yes Testosterone replacement ◯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:

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

Name_____ **SAN DIEGO SEXUAL MEDICINE**

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** or **very often…**
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   ◯ Yes ◯ No

2. Did a parent or other adult in the household **often** or **very often…**
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   ◯ Yes ◯ No

3. Did an adult or person at least 5 years older than you **ever…**
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   ◯ Yes ◯ No

4. Did you **often or very often** feel that**…**
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   ◯ Yes ◯ No

5. Did you **often or very often** feel that**…**
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ◯ Yes ◯ No

6. Were your parents **ever** separated or divorced?
   ◯ Yes ◯ No

7. Was your mother or stepmother:
   Often or very often pushed grabbled, slapper, or had something thrown at her?
   or
   Sometimes, often or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   ◯ Yes ◯ No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ◯ Yes ◯ No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   ◯ Yes ◯ No

10. Did a household member go to prison?
    ◯ Yes ◯ No