Urology of Indiana

New Patient Survey For Patients Visiting The Men's Health Center for Bladder Leakage

Clinic - (317) 564-5104 | Surgery Scheduling - (317) 807-0159

Name: _____

Age and Date of Birth: _____

1) How long have you been having difficulties holding your urine? (Please write a number and **please circle years or months**)

__ years / months

2) Do you leak urine when you cough, sneeze, or lift something heavy?

Yes / No

3) Do you ever get the sudden urge to urinate while resting, but then leak because you can't get to the bathroom in time?

Yes / No

4) Have you sought treatment for this issue before?

Yes / No

If so, who did you see? List name and please write any medications, procedures, or exercises that you've tried.

Explain:_____

_____

5) Is your leakage the result of prostate removal for prostate cancer?

Yes / No

If yes, in what year/month was your prostate removed? If you can, please list the name of your surgeon and whether your surgery was robotic or open.

Explain: _____

Experience bladder leakage along? Complete pages 1-2. Bladder leakage and ED? Complete pages 1-7.

6) Approximately how many pads or Depends are you using in a day? (ex. 2 pads per day, 3 Depends per day)

Explain: _____

7) If you go to bed with a fresh dry pad, is it wet when you wake up? (waking up to urinate is ok, we want to know if you leak urine while sleeping)

Yes / No

8) Have you ever required surgery for scar tissue in your urethra or bladder?

Yes / No

If yes, please explain:_____

9) Have you ever had radiation to your pelvis?

Yes / No

10) If you were urinating into a toilet, would you be able to 'pinch off' your urine stream using just your pelvic muscles? (imagine someone accidentally walked in and you wanted to stop urinating mid-stream)

Yes / No / Not sure

11) Do you have any difficulties with your erections?

Yes / No

If you answered yes, is this something you'd like to have fixed?

Yes / No

12) What do you do for a living? If retired, what did you use to do?

_____

If you answered 'Yes' to both parts of question #11, please complete the attached ED questionnaire. If you don't have erectile difficulties or you do but do not wish to have your sexual function restored, you can return the following pages blank.

New Patient ED Questionnaire

1) How long have you been having difficulties with your erections?

__ years / months

2) Have you sought treatment for this issue before?

Yes / No

If so, who did you see? List name or leave blank if you have not sought care for this issue before.

Name: _____

3) Have you tried any interventions to help improve your erections? (ex. oral medications, penile injections, vacuum device...)

Yes / No

If yes, please list: _____

4) Were these treatments effective when you first tried them? Circle yes or no. Please leave blank if you answered 'no' to the previous questions and have not tried anything to improve your erections yet.

Yes / No

5) Are any of these interventions still working for you currently? Why or why not?

Yes / No

Explain: _____

6) Would you say you have greatest difficulty with ACHIEVING an erection, MAINTAINING an erection, or BOTH?

Achieving / Maintaining / Both

7) If you had to rank the rigidity of your average erection (without medication) from 0-10 with 0 being no erection and 10 being the most rigid erection you've ever had, what ranking would you give?

___ (out of 10)

8) Is this erection sufficient for penetration?

Yes / No

9) Do you still experience erections in the middle of the night or when you wake up in the morning?

Yes / No

10) Do you currently use any tobacco or nicotine containing products? If yes, please list the product, the amount, and duration of use. (ex. Cigarettes, 1 pack per day for 20 years)

Yes / No

Product / amount / duration? _____

11) If do not currently use any tobacco or nicotine containing products, but used to, please list what you used to use, the amount, the duration, and when you stopped using. (ex. Cigarettes, 1 pack per day for 20 years, Quit 5 years ago)

Product / amount / duration? _____

12) How many alcoholic beverages do you think you have in an average week? (ex. 4 beers a week)

Amount: _____

13) Do you use any other substances that don't come from physician? (ex. marijuana)

Yes / No

If yes, please list: _____

14) Do you have diabetes?

Yes / No

If yes, please list medications you take for this and your most recent A1C level:

- _____
- _____

15) Do you have high blood pressure?

Yes / No

If yes, please list medications you take for this:

- _____

16) Do you have any history of heart disease, stroke, or other vascular disease?

Yes / No

If yes, please explain and list any medications you take for this. This should include any blood thinners like Plavix (clopidogrel), Xarelto (rivaroxaban), or Coumadin (warfarin):

- _____
- _____
- _____

17) Have you ever had your testosterone levels checked? If yes, how long ago and by whom? If yes, do you remember if the results were normal or not?

Yes / No

Explain: _____

18) Have you had any other surgeries in the pelvis or groin? (ex. hernia repair, bladder removal)

Yes / No

If yes, please explain: _____

19) Have you ever experienced difficulty with climaxing too early (also known as premature ejaculation)?

Yes / No

The IIEF-5 Questionnaire (SHIM)

Please encircle the response that best describes you for the following five questions:

Over the past 6 months:					
1. How do you rate your confidence that you could get and keep an erection?	Very low 1	Low 2	Moderate 3	High 4	Very high 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost never of never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5

Total Score: _____

Experience bladder leakage along? Complete pages 1-2. Bladder leakage and ED? Complete pages 1-7.