Amir Saffarian, M.D. Inc.
18181 Butterfield Blvd suite 185, Morgan Hill, CA 95037
Office: 408-779-2009 Fax: 408-779-2011

Name (First,Middle,Last) Male/Female Date of Birth SSN

Home Address City Zip code

Home Number Cell Number Work Number E-Mail Address

Marital Status Name of Spouse Preferred Language

Employer: Full Time/Part Time

Ethnicity **(select one)** Caucasian Hispanic African-American Middle Eastern Asian

Nearest Friend/Relative **(not living with you)** Relationship Contact Number

Reminder call Preference: Email Text message phone call

Family Physician_____ Phone
Other Physicians_____ Phone

IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)
Mother's Name_____Phone_____Date of Birth_____
Address_____SSN_____
Employer_____Phone_____
Father's Name_____Phone_____Date of Birth
Address_____SSN_____E
mployer_____Phone_____

PRIMARY INSURANCE:
Company Name_____
SECONDARY INSURANCE:
Company Name_____

WHICH PHARMACY DO YOU USE?
Name_____Phone#_____

WHICH LABORATORY DO YOU USE?
NAME: PHONE #_____.

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MALE PATIENT QUESTIONNAIRE:

Name _____ Family Physician _____ Date_____

Reason for Visit -

_____

_____

Urinary Symptoms	**Yes**	**No**
Does your urination start immediately?	____	____
Is your urinary stream slow?	____	____
Do you have significant urgency with urination?	____	____
Do you awaken at night to urinate?	____	____
If yes, how many times?	____	
Do you push or strain with urination?	____	____
When you finish urinating, do you feel empty?	____	____
Does it burn or sting when you urinate?	____	____
How many times do you urinate during the day?	____	
Do you leak urine with straining or coughing?	____	____
Do you leak urine while trying to reach bathroom?	____	____
If yes to either of the above, do you use pads?	____	____
If yes, how many?	____	
Have you ever seen an urologist before?	____	____
If yes, why and what was done?	_____	

_____

Urinary Tract Infections	**Yes**	**No**
Have you ever had a prior urinary tract infection	____	____
If yes, how many?	_____	
Age infections started?	_____	
Last infection?	_____	
Have you ever had a prostate or kidney infection?	____	____
Have you ever had a fever with infection?	____	____
Have you ever had pain in the back with infection?	____	____
Have you ever had X-rays of the kidney?	____	____
Were you ever hospitalized to treat an infection?	____	____
Have you ever had a sexually transmitted disease?	____	____

I have reviewed the contents of this history in its entirety. _____MD Date _____

Kidney Stones **Yes** **No**

Do you have any pain in the back or abdomen? ____ ____

Have you ever had a kidney stone before? ____ ____

If yes, when? _____

How many? _____

Passed on own? _____

Surgically removed? _____ What was the stone made of? _____

Did you have a work-up to determine the cause? ____ ____

Any prior dietary changes or medications? ____ ____

If yes, what?_____

_____

Hematuria **Yes** **No**

Have you ever seen blood in your urine? ____ ____

If yes, when? _____

How many times? _____

Did you have any pain or burning at the time? ____ ____

Has a doctor ever found blood with a microscope? ____ ____

Have you ever had prior work up for this problem? ____ ____

If yes, when? _____

What was done? _____ What was found? _____

Erectile Dysfunction **Yes** **No**

Do you have a trouble with erections? ____ ____

If yes- Do you awaken with a good erection? ____ ____

Do you have trouble obtaining an erection? ____ ____

Do you have trouble maintaining an erection?____ ____

Do you have curvature with erections? ____ ____

Is sex an important part of your life? ____ ____

On a scale of 1 to 10 rate the quality of your erections _____

How often are you able to complete sexual intercourse? ____%

Medical History	Gout	Dementia
COPD	Skin cancer	Heart Attack
GERD	Sleep apnea	Diabetes
Prostate cancer	High Cholesterol	Other:
Bipolar disorder	Stroke	
Autoimmune Disease	Hypertension	None
Prostate cancer	Lung cancer	

Surgical History

Surgery	Date	Disease
1.		
2.		
3.		
4.		

Medications

Name	Dosage	How often (i.e. once or twice a day)

Please make sure to include blood thinners (i.e. aspirin, plavix, coumadin, ibuprofen or herbal medications)

1. _____
2. _____
3. _____
4. _____

Allergies □ No Known Drug Allergies

Name of medication	Reaction
1.	
2.	

Family History (Include High blood pressure, diabetes, cancer etc.)

(Also include prostate, kidney or bladder cancer or problems)

Family Member	Age	Disease
1.	Father	
2.	Mother	
3.		

Social History	Yes	No
Do you or have you ever smoked?	____	____
If yes, how much? _____packs/day		
How long? _____		
Have you quit?	____	____
If yes, when? _____		
Do you drink alcohol?	____	____
If yes, how much? _____		
How long? _____		
Are you employed?	____	____
If yes, what type of work?	_____	
Do you drink caffeinated drinks? (i.e coffee, energy drinks)	_____	_____

TRAVEL HISTORY

HAVE YOU TRAVELED WITHIN THE LAST 30 DAYS? **YES** **NO**

Only pertains to if you have gone outside of the US if so where?

HAVE YOU DEVELOPED ANY OF THE FOLLOWING SYMPTOMS WITHIN THE LAST 30 DAYS?

NONE FEVER RASH COUGH DIARRHEA

BODYACHE HEADACHE OTHER

HAVE YOU BEEN EXPOSED TO OR BEEN AROUND A SICK PERSON WITHIN THE LAST 30 DAYS? **YES** **NO**

SCREENING FORM

PHQ- Depression Screening

Little interest or pleasure in doing things?

YES **NO**

Feeling down, depressed or hopeless?

YES **NO**

PHQ-2 Depression Screening-*frequency of the following problems over the past two weeks*

Little interest or pleasure in doing things

0-not at all **1- Several days** **2- More than half the days** **3- Nearly every day** **4-**

Feeling down, depressed, or hopeless

0-not at all **1- Several days** **2- More than half the days** **3- Nearly every day**

Review of Systems

***Please underline which symptoms you have RECENTLY experienced.**

Constitutional (fevers, chills, headache)

Integumentary (skin rash, itchiness, dryness, Boils)

Eyes (blurred vision, Double vision pain in eyes,)

Ears, nose and throat (Sore throat, ear infection, ear pain, hearing loss Sinus problems)

Neurologic (tremors, dizzy spells, Numbness/tingling)

Endocrine (tiredness, excessive thirst, too hot/cold)

Heart (chest pain, heart attack, high blood pressure.)

Lungs (shortness of breath, TB, asthma cough, wheezing.)

Gastrointestinal (GERD, ulcers, hepatitis, abdominal pain, nausea, vomiting)

Hematologic (Excessive bleeding, blood clots, lymphoma, anemia)

Psychiatric (depression,anxiety, Mental illness)

Musculoskeletal (Arthritis,GOUT, disc disease)

Social History

Please circle if any of these pertain to you:

Military Service	**Stress Concern**	**Seat Belt**	**Sleep Concern**
Blood Transfusion	**Weight Concern**	**Self- Exams**	**Bike Helmet**
Caffeine Concern	**Special Diet**	**Exercise**	
Occupational Exposure	**Back Care**	**Hobby Hazards**	

	0 Not at all	**1** Less than 1 in 5	**2** Less than half the time	**3** About half the time	**4** More than half the time	**5** Almost always
Over the past month, how often have you had the sensation of not completely emptying your bladder after urinating?						
Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?						
Over the past month, how often have you stopped and started several times during urination?						
Over the past month, how often have you found it difficult to postpone urination?						
Over the past month, how often have you had a weak urinary stream?						
Over the past month, how often have you had to push or strain to begin urination?						
During the night, how many times do you get up to urinate?	None	1 time	2 times	3 times	4 times	5 times or more

Score results: mild 0-7 moderate 8-19 severe 20-35

Total symptom score _____

BLADDER SATISFACTION SURVEY

Which symptoms best describe you?

Frequent Urination – Day, Night, or Both Leaking with Sneezing, Coughing, Exercising

Sudden or Strong Urge to urinate Leaking with Urge or No Warning (Unable to make it to the bathroom in time)

Unable to Empty the Bladder Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

Detrol® LA Ditropan XL® Flomax® Cardura® Gelnique®

Oxytrol® Patch Enablex® VESIcare® DDAVP® Toviaz®

Sanctura® Elavil® Elmiron® Other_____

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief Completely Cured

If you've stopped taking your meds explain why:
Did not Help Side Effects Too Expensive
Describe Side Effects _____

Behavior Modifications Tried_____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated Very Frustrated

Do you currently have any problems with bowel function?: Fecal Incontinence
Constipation Other

I am interested in learning more about treatment alternatives to medications:
Yes No