

Thank you for your recent submission and interest in having treatment for your enlarged prostate/bph. Dr. Bagla would benefit from some additional information about you.

Please fill out and return the forms that follow, via email, along with a photocopy of your driver's license/ID card and your health insurance card (front and back).

If you have any questions regarding the procedure or the process, please don't hesitate to contact me. I will help in any way that I can.

Best regards,

Sandeep Bagla, MD  
sandeep.bagla@gmail.com



# PAE Patient Demographics Form



---

## YOUR CONTACT INFORMATION

LAST NAME:

FIRST NAME:

DOB:

EMAIL:

Primary Phone

Home

Work

Mobile

PHONE NUMBER:

Social Security Number:

STREET ADDRESS:

CITY, STATE:

ZIP:

Pay Method

self-pay

submit to insurance

Insurance Carrier:

Insurance Phone:

Policy Number:

Group Number:

Subscriber Name/  
Relation:

Subscriber DOB:

Primary Care Physician:

Primary Care Phone:

---

PERSONAL MEDICAL HISTORY	FAMILY MEDICAL HISTORY	
<i>Please check all that apply to you:</i>	<i>Please check all that apply to your parents:</i>	
	<i>MOTHER</i>	<i>FATHER</i>
Diabetes		
High Blood Pressure		
Heart Attack		
Pacemaker		
Stroke		
Bleeding Problems		
Heart Disease		
Asthma		
Emphysema		
Kidney Disease		
Liver Disease		
HIV/AIDS		
Seizures		
Cancer If so, what type?		

Cigarettes?    # packs/day                      Previously                      Never

Alcohol?        # drinks/day

Caffeine?        # drinks/day

Allergies: (list all medications, anesthetics, contrast agents, etc.)



## AUA SYMPTOM SCORE

Last Name	First Name	Date

Please complete the questions below by choosing your response level and then putting the corresponding number in the blue box below that choice. *i.e. if your answer to question 1 is less than half the time enter the number 2 in the blue box. If it is almost always enter 5 in the blue box. Your scores will total automatically at the bottom. Complete the final question on how you feel by placing an X in the box next to the corresponding response.*

1. Incomplete emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

2. Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

3. Intermittency: Over the past month, how often have you found that you stopped and started again several times when you urinated?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

4. Urgency: Over the past month, how often have you found it difficult to postpone urination?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

5. Weak-stream: Over the past month, how often have you had a weak stream?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

6. Straining: Over the past month, how often have you had to push or strain to begin urination?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

7. Nocturia: Over the past month or so, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

TOTAL AUA SCORE \_\_\_\_\_

Quality of Life Due to Urinary Symptoms: If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? *Place an X in the box next to the corresponding response.*

- Delighted  
  Pleased  
  Mostly satisfied  
  Mixed  
  Mostly dissatisfied  
  Unhappy  
  Terrible

## REVIEW OF SYSTEMS

Do you have any problems now or have you had any related to the following systems? Indicate Yes or No

CONSTITUTIONAL SYMPTOMS	YES	NO	MUSCULOSKELETAL	YES	NO
Fever			Muscle Weakness		
Chills			Joint Pain (Swelling)		
Weight change			Arthritis		
HEIGHT:			History of Orthopedic Surgery		
WEIGHT:			Chronic Back Pain		
<b>EYES</b>			Chronic Neck Pain		
Glaucoma			Comments?		
Cataracts			<b>NEUROLOGICAL</b>		
Blurry Vision			Tremors		
Double Vision			Dizzy Spells		
Comments?			Numbness/Tingling		
<b>CARDIOVASCULAR</b>			Stroke		
Chest Pain			Weakness		
Heart Attack			Difficulty Walking		
Irregular Heartbeat			Loss of Bowel Control		
Ankle Swelling			Comments?		
High Blood Pressure			<b>HEMATOLOGIC/LYMPHATIC</b>		
Angina			Swollen Glands		
Congestive Heart Failure			Blood Clotting Problem		
Problem with Heart Valves			Easy Bleeding/Bruising		
Rheumatic Fever			Anemia		
Comments?			Enlarged Lymph Nodes		
<b>PSYCHOLOGICAL</b>			Transfusion History		
Anxiety			Immune Deficiency		
Depression			Comments?		
Difficulty Sleeping			<b>RESPIRATORY</b>		
Comments?			Wheezing		
<b>GENITOURINARY</b>			Chronic Cough		
Change in Stream			Shortness of Breath		
Nocturia (getting up at night)			Emphysema		
Urinary Frequency (>8 times/day)			Exposure to Tuberculosis		
Dysuria (burning with urination)			Comments?		
Blood in Urine			<b>GASTROINTESTINAL</b>		
Urinary Tract Infection			Abdominal Pain		
Kidney Stones			Nausea/Vomiting		
Urinary Leakage			Indigestion/Heartburn		
Comments?			Constipation		
<b>ENDOCRINE</b>			Diarrhea		
Excessive Thirst			Bloody or Dark Stools		
Too Hot/Cold			Change in Bowels		
Thyroid Condition			Comments?		
Diabetes					
Comments?					

## REVIEW OF SYSTEMS (CONTINUED)

---

SEXUAL HISTORY		YES	NO
Change in Sex Drive			
Poor Sexual Performance/Lack of Erection			
Have you had a PSA?			
Date:		Result:	

Have you had any of the the following prostate procedures? If yes, when?

TURP

Laser/Greenlight

TUNA

Microwave

Urolift

Prostatectomy

Stent

Other

# The IIEF-5 Questionnaire (SHIM)

1. How do you rate your confidence that you can get and keep an erection?
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?
3. During sexual intercourse, how often were you able to maintain an erection after you had penetrated your partner?
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
5. When you attempted sexual intercourse, how often was it satisfactory for you?

Please total your score from above here: