San Diego Sexual Medicine

PATIENT REGISTRATION

Your paperwork must be completed before your appointment.

Patient Name_________________________________ Sex ☐ M ☐ F Date _____________________

Social Security Number _____________ Birth Date ________________ Partner's Name ____________________

☐ Single ☐ In relationship ☐ Co-habitating ☐ Married/Domestic Partnership ☐ Divorced/Separated ☐ Other

Mailing Address: ____

Phone(s) (H) _________________________ (W) ________________________ (C) __________________________

Preferred phone: ☐ Home ☐ Work ☐ Cell 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 prior 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

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
Eric Biewenga, MD
Vera Trofimenko, MD
Rose Hartzell, PhD
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 the 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: _________________

San Diego Sexual Medicine

MEDICAL HISTORY

Name ____ Date __________________

Date of birth __________________ Age____ Height ___ft_____in Weight _____________ lbs

☐ Married ___ yrs ☐ Monogamous Relationship ___ 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)*

☐ Hypertension ☐ Diabetes

☐ Heart Disease ☐ Neurologic disease (e.g. MS)

☐ Stroke ☐ Asthma

☐ High Cholesterol ☐ Incontinence

☐ Thyroid problems ☐ Genital conditions _______________________

Family history of any of the above conditions:

☐ *Hypertension* ☐ *Thyroid problems*

☐ *Heart Disease* ☐ *Diabetes*

☐ *Stroke* ☐ *Neurologic disease (e.g. MS)*

☐ *High Cholesterol* ☐ *Asthma*

☐ *Urinary tract disease* ☐ *Incontinence*

- -

☐ Cancer: Type________________ Treatments: ____

☐ Previous surgeries: Type and Date ____

____

☐ Other medical disorders: ____

____

☐ Depression ☐ Other psychological disorders: ____

____

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

Do you ever drink alcohol? N Y _____ drinks/ day

Do you eat/drink food with caffeine? N Y ____

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

☐ Military service ☐ Criminal history ____

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

- ☐ Genitourinary conditions
- ☐ Urinary tract infection
- ☐ Abnormal vaginal or urethral discharge
- ☐ Sexually transmitted disease
- ☐ Yeast infections
- ☐ Ovarian conditions
- ☐ Interstitial cystitis
- ☐ Cervical dysplasia
- ☐ Perineal trauma
- ☐ Endometriosis
- ☐ Vestibular adenitis
- ☐ Breast conditions

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?______

SEXUAL HISTORY – PART I

Name ____ Date ___________________

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? N Y ______ yrs
Location: ____
Description: ____
Triggered by: ____
Made worse by: ____
Made better by: ____
To what do you attribute your sexual dysfunction? *Check call that apply:*

- ☐ Injuries ☐ Childbirth ☐ Surgery ☐ Sexual Abuse
- ☐ Medications: ____
- ☐ Other: ____

Have you ever fallen on your crotch on a hard object?(bicycle bar, fence) N Y
Please explain: ____
____

Are you a bike rider? N Y Are you a horse rider? N Y
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? N Y Does partner have sexual problems? N Y
Please explain: ____
____
____

San Diego Sexual Medicine

SEXUAL HISTORY – PART II

Name ____ Date __________________

Previous jobs____
Last worked_____________ Ever on disability? N Y

Currently in a sexual relationship? N Y Sexual activities do you engage in with this partner:
____

Childhood religion _________________________ Current religion ___________________________

<u>Sexual History</u>

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

Have sexual fantasies ☐ No ☐ Yes Age began _______ Do you now ☐ No ☐ Yes

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

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

Name ____ Date ___________________

Please check all that apply:

- ☐ Depressed mood
- ☐ Diminished interest
- ☐ Significant weight loss or gain
- ☐ Feelings of worthlessness
- ☐ Feelings of guilt
- ☐ Sleep disruption
- ☐ Fatigue
- ☐ Diminished ability to concentrate
- ☐ Change in motivation
- ☐ Tearfulness
- ☐ Expansive mood lasting a week or longer with
  - ☐ Decreased need for sleep
  - ☐ Shopping sprees
  - ☐ More talkative
  - ☐ Sexual indiscretions
  - ☐ Flight of ideas
  - ☐ Foolish business investment
  - ☐ Distractibility
- ☐ Heart palpitations
- ☐ Trembling
- ☐ Sensations of shortness of breath
- ☐ Feeling of chocking
- ☐ 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
- ☐ Sweating
- ☐ Chills or hot flashes
- ☐ Excessive worries
- ☐ Difficulty controlling worries
- ☐ Restlessness
- ☐ Fatigue
- ☐ Difficulty concentration
- ☐ Irritability
- ☐ Muscle tension
- ☐ Sleep disturbance

Name ____ Date ____________________

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

- ☐ Referral
- ☐ Internet
- ☐ Television/Radio
- ☐ Newspaper/Magazine
- ☐ Book

I was referred to

- ☐ Dr. Irwin Goldstein
- ☐ Dr. Rose Hartzell
- ☐ 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 be sent 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

_______________________________________ Date _________________________

Signature

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: ________________________________