

# Patient Information

Name: \_\_\_\_\_  
Last First MI

Email address: \_\_\_\_\_  
 I wish to opt out of any clinic updates via email. This includes: newsletters, deals, coupons, and promotions.

Street Address: \_\_\_\_\_ City State Zip

PO Box: \_\_\_\_\_

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Other) \_\_\_\_\_

Can we call you at work?  Yes  No

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Race  Caucasian  African American  Asian  Native American  Latin American  Other \_\_\_\_\_

Ethnicity  Hispanic  Latino  Non-Hispanic / Non-Latino

Military History:  Active  Veteran  N/A

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

If you heard from a friend, who? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

**SIGNATURE (X)** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The treating medical provider, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the medical provider. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. Any prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

Sign here: X \_\_\_\_\_ I have read and understand the above consent form.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Northwoods Family Physical Medicine.

(Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of Northwoods Family Physical Medicine to leave reminder messages on voicemail/answering machines, or with another person in the household. I may make a request of an alternative means of communication (within reason) in writing.

May we discuss your medical condition with any member of your family?	YES	NO
May we discuss your billing information with any member of your family?	YES	NO

If YES, please name the members allowed:

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X \_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Witness (Office Staff)

\_\_\_\_\_  
Date

## History of Present Illness – PRP Procedures

Do you currently have, or have been diagnosed with, or have had in the past, any of the following:

- Platelet dysfunction syndrome
- Critical thrombocytopenia
- Hemodynamic instability
- Septicemia
- Local infection at the site of the procedure(s)
- Areas of active inflammation or infection (cysts, pimples, rash)
- Sexually transmitted disease or blood borne infection
- Excessively sensitive skin, healing problems, dermatitis or inflammatory Rosacea
- Systemic use of corticosteroids within 2 weeks
- Corticosteroid injection at treatment site within 1 month
- Cancer – Type: \_\_\_\_\_
- History of allergies, rashes or other skin reactions that may be sensitive to treatment
- Active or past vaginal/uterine or other female related problems
- Have you had a normal gynecological exam within the last year and have not had any gynecological/female issues since?
- Active or past bladder/prostate/penile or other male related problems

Name \_\_\_\_\_

## FEMALE SEXUAL FUNCTION INDEX

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Instructions: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions, the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation, and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

### **CHECK ONLY ONE BOX PER QUESTION.**

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?

- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?

- Very high
- High
- Moderate
- Low
- Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

- No sexual activity
- Very high confidence
- High confidence
- Moderate confidence
- Low confidence
- Very low or no confidence

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

- No sexual activity
- Very high
- High
- Moderate
- Low
- Very low or none at all

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

- No sexual activity
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated (“wet”) during sexual activity or intercourse?
- No sexual activity
  - Almost always or always
  - Most times (more than half the time)
  - Sometimes (about half the time)
  - A few times (less than half the time)
  - Almost never or never
8. Over the past 4 weeks, how **difficult** was it to become lubricated (“wet”) during sexual activity or intercourse?
- No sexual activity
  - Extremely difficult or impossible
  - Very difficult
  - Difficult
  - Slightly difficult
  - Not difficult
9. Over the past 4 weeks, how often did you **maintain** your lubrication (“wetness”) until completion of sexual activity or intercourse?
- No sexual activity
  - Almost always or always
  - Most times (more than half the time)
  - Sometimes (about half the time)
  - A few times (less than half the time)
  - Almost never or never
10. Over the past 4 weeks how **difficult** was it to maintain your lubrication (“wetness”) until completion of sexual activity or intercourse?
- No sexual activity
  - Extremely difficult or impossible
  - Very difficult
  - Difficult
  - Slightly difficult
  - Not difficult
11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?
- No sexual activity
  - Almost always or always
  - Most times (more than half the time)
  - Sometimes (about half the time)
  - Almost never or never
12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?
- No sexual activity
  - Extremely difficult or impossible
  - Very difficult
  - Difficult
  - Slightly difficult
  - Not difficult
13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?
- No sexual activity
  - Very satisfied
  - Moderately satisfied
  - About equally satisfied and dissatisfied
  - Moderately dissatisfied
  - Very dissatisfied
14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?
- No sexual activity
  - Very satisfied
  - Moderately satisfied
  - About equally satisfied and dissatisfied
  - Moderately dissatisfied
  - Very dissatisfied
15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?
- Very satisfied
  - Moderately satisfied
  - About equally satisfied and dissatisfied
  - Moderately dissatisfied
  - Very dissatisfied
16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?
- Very satisfied
  - Moderately satisfied
  - About equally satisfied and dissatisfied
  - Moderately dissatisfied
  - Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?

- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

19. Over the past 4 weeks, how would you rate your level (degree) of discomfort or pain during or following vaginal penetration?

- Did not attempt intercourse
- Very high
- High
- Moderate
- Low
- Very low or none at all

***Thank you for completing this questionnaire.***