

# 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 \_\_\_\_\_

## The IIEF-5 Questionnaire (SHIM)

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

<b>Over the past 6 months:</b>					
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:** \_\_\_\_\_

1-7: Severe ED    8-11: Moderate ED    12-16: Mild-moderate ED    17-21: Mild ED    22-25: No ED