San Diego Sexual Medicine

PATIENT REGISTRATION

Your paperwork must be completed before your appointment.

Patient Name _____ Sex ____ Date _____

Social Security Number _____-____-_____ Birth Date_____/___/_____Partner's Name _____

Single__ In a Relationship__ Co-habitating__ Married/Domestic Partnership__ Divorced/Separated__ Other_____

Mailing Address: _____

Phone(s) (H) _____ (W) _____ (C)_____

Preferred phone: H / W / C 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 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 Numbe

Signature Date

San Diego Sexual Medicine

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
Catherine Gagnon, FNP-BC
Julea Minton, NP-C

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 that 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.

_____ Date: _____

Signature

San Diego Sexual Medicine

Name _____ Date_____

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

- ☐ Referral
- ☐ The internet
- ☐ Television/radio _____
- ☐ A newspaper/magazine _____
- ☐ A book _____

I was referred to:

- ☐ Dr. Irwin Goldstein
- ☐ 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 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

_____ _____

Signature Date

San Diego Sexual Medicine

MEDICAL HISTORY - PART I

Name ____________________ Date ____________________

Gender at birth _______ Gender identity _______ Preferred pronouns ____________

Major childhood illnesses: ____________________

Medications: ____________________

____

____

Drug allergies: ____________ Food allergies ____________

Latex allergy: ____________ Other allergies ____________

Allergic reaction: ____________________

Adverse reaction: ____________________

Have you ever had any of the following medical conditions? *(Check all that apply)* ☐ None of these

☐ Migraines ☐ aura ☐ no aura
☐ Hypertension
☐ High Cholesterol
☐ Heart Disease
☐ Stroke/DVT/Blood clot in lungs
☐ Breast conditions ____________
☐ Prolapse ☐ uterine ☐ rectal ☐ vaginal
☐ Kidney disease
☐ Incontinence
☐ Interstitial cystitis
☐ Liver disease
☐ Chronic urinary tract infections (>3/yr)
☐ DES (Diethylstilbestrol)
☐ Abnormal Pap treatment date ____________
☐ Cancer: Type____________ Treatments: ____________
☐ Trauma ☐ Perineal ☐ Genital
☐ Other medical disorders ____________
☐ Chronic vaginal infections (>3/yr)
☐ Endometriosis
☐ PCOS
☐ Thyroid problems ☐ hyper ☐ hypo
☐ Diabetes
☐ Osteoporosis ☐ Osteopenia
☐ Sexually transmitted disease ____________
☐ Seizure disorder
☐ Neurologic disease (e.g. MS)
☐ Suicide attempt
☐ Depression
☐ Anxiety
☐ Other psychological disorders ____________
☐ Bleeding disorder____________

Family history of any of the above conditions? *(Check all that apply)* ☐ None of these

☐ *Hypertension*
☐ *Heart Disease*
☐ *Stroke*
☐ *High Cholesterol*
☐ *Blood/clotting disorder*
☐ *Thyroid problems*
☐ *Diabetes*
☐ *Neurologic disease (e.g. MS)*
☐ *Asthma*
☐ *Cancer (other than basal cell)*

- -

Do you eat/drink food with caffeine? No ☐ Yes ☐ ____________

Current smoker? No ☐ Yes ☐ _____ yrs Have you ever smoked? No ☐ Yes ☐ _____ packs/day

Do you ever drink alcohol? No ☐ Yes ☐ _____ drinks/day

Do you use any recreational drugs (marijuana, cocaine, heroin, etc.): No ☐ Yes ☐

Please describe: ____________________

Criminal history No ☐ Yes ☐ ____________________

Military service No ☐ Yes ☐

☐ Single ☐ Married _____ yrs ☐ Committed Relationship _____ yrs ☐ Monogamous _____ yrs

☐ Divorced ☐ Widowed ☐ Other ____________ Age: _____ Height: _______ Weight:______

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MEDICAL HISTORY - PART II

Name _____ Date_____

Current contraceptive method: _____
Have you EVER used contraception:
Type: _____Age of onset: _____ For how long?_____
Type: _____Age of onset: _____ For how long?_____
Type: _____Age of onset: _____ For how long?_____
Dates: _____
Deliveries: Vaginal ____ Cesarean ____ No. of pregnancies:____ Miscarriage: _____ Abortion: ____
Biologic children ____ Stillbirths ____ Infertility Treatment ☐ Yes ☐ No Date _____
Living children (your age/other parent): _____
_____
_____
Stillbirths/abortions (your age/other parent): _____
_____
Age of first menstruation: _____ Are menses regular? ☐ Yes ☐ No
Pain with menstruation? ☐ Yes ☐ No Length period in days: _____ Length cycle in days: _____
If you are menopausal, age of menopause: _____ Are you on hormone therapy? ☐ Yes ☐ No
Type: _____ For how long?_____
Type: _____ For how long?_____
Type: _____ For how long?_____
Type: _____ For how long?_____
Breast exams self-exam recently? ☐ Yes ☐ No Do you have regular pap smears? ☐ Yes ☐ No
Date of last pap smear _____ Date of last mammogram _____

Past Sexual Treatments *(Check all that apply)*

Diet	☐ Yes ☐ No	Testosterone	☐ Yes ☐ No
Regular exercise	☐ Yes ☐ No	Wellbutrin, cabergaline, ropinerole	☐ Yes ☐ No
Medication changed	☐ Yes ☐ No	MonaLisa/Laser Treatment	☐ Yes ☐ No
Pelvic floor PT	☐ Yes ☐ No	Radiofrequency RF Therapy	☐ Yes ☐ No
Vibrator to orgasm	☐ Yes ☐ No	Shockwave	☐ Yes ☐ No
Sex Therapy	☐ Yes ☐ No	Stem Cell Treatment	☐ Yes ☐ No
Counseling	☐ Yes ☐ No	PRP	☐ Yes ☐ No
CBT	☐ Yes ☐ No	Addyi	☐ Yes ☐ No
Psychiatric therapy	☐ Yes ☐ No	Vyleesi	☐ Yes ☐ No
Cialis, Levitra, Stendra, Viagra	☐ Yes ☐ No	Recreational drugs	☐ Yes ☐ No
		Other _____	

Hysterectomy ☐ Yes ☐ No Date _____
Oophorectomy ☐ Yes ☐ No Date _____
Episiotomy ☐ Yes ☐ No
Previous surgeries Type and Date _____

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SEXUAL HISTORY – PART I

Name _____ Date_____ Preferred Pronoun _____

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?	Yes / No	Years: _____

Location: _____

Description:_____

Triggered by: _____

Made worse by: _____

Made better by: _____

To what do you attribute your sexual dysfunction? *Circle call that apply:*

Injuries Childbirth Surgery Sexual Abuse

Medications: _____

Other: _____

Have you ever fallen on your crotch on a hard object?(bicycle bar, fence) Yes / No

Please explain: _____

_____

Are you a bike rider? Yes / No Are you a horse rider? Yes / No

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? Yes / No Does partner have sexual problems? Yes / No

Please explain: _____

_____

_____

San Diego Sexual Medicine

SEXUAL HISTORY – PART II

Name _____ Date_____

Previous jobs_____
Last worked_____ Ever on disability ☐ No ☐ Yes

Currently in a sexual relationship ☐ No ☐ Yes Sexual activities do you engage in with this partner:
_____

Childhood religion _____ Current religion _____

Sexual History
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
Did you ever have sexual fantasies ☐ No ☐ Yes Age began _____ Do you now ☐ No ☐ Yes
Did you 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 ☐ Transgender
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

Please check all that apply:

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

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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: _____