Office of Dr. Ash K. Tewari, MD
Chairman Dept. of Urology
Icahn School of Medicine at Mount Sinai
Ph: (212) 241-9955

Mount Sinai

Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____

Email: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact (Relationship) and Number: _____

Reason for Visit: _____

Referring MD:

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Would you like this MD to be notified? Yes No

Primary Care Physician:

☐ Check if PMD is the Referring MD

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Would you like this MD to be notified? Yes No

Urologist:

☐ Check if Urologist is the Referring MD

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Would you like this MD to be notified? Yes No

Cardiologist:

☐ Check if Cardiologist is the Referring MD

☐ Check if Cardiologist is the Primary Care MD

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Would you like this MD to be notified? Yes No

Is there anyone else who you would like for us to notify of your medical status? Please list them here:

Name:

Address:

Phone #:

Fax #:

Name:

Address:

Phone #:

Fax #:

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Date: _____ Reason for Today's Visit: _____

Name: _____ DOB: _____ Age: _____

Past Medical History

- ☐ Hypertension
- ☐ Heart Murmur
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Blood Clots
- ☐ Seizure Disorder
- ☐ High Cholesterol
- ☐ Thyroid Disorder
- ☐ Hemorrhoids / IBS
- ☐ Hernia
- ☐ Stroke / Heart Disease
- ☐ Enlarged Prostate
- ☐ Sexual Dysfunction
- ☐ Other: _____

Surgical History

_____

Medication Name and Dosage (including supplements)

_____

Allergic to any meds? No ○ ○ Yes

If yes, list medication & reaction: _____

Social History

Occupation: _____

Marital Status: _____

Children: No ○ ○ Yes Number: _____

Smoke: No ○ ○ Yes (list # packs and years) _____

Alcohol: No ○ ○ Yes (list drinks per week) _____

Caffeine: No ○ ○ Yes (list # per day) _____

Family History	Yes	No	Family Member
Prostate Cancer	○	○	
Colon Cancer	○	○	
Bladder Cancer	○	○	
Heart Disease	○	○	
Other: _____	○	○	

Review of Systems

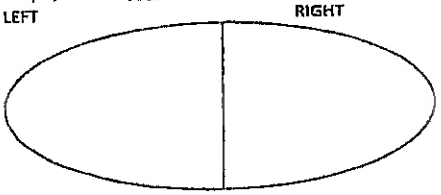
Constitutional		
Significant Changes in Weight	Yes ○	○ No
Fevers and Chills	Yes ○	○ No
Fatigue	Yes ○	○ No
Persistent Headaches	Yes ○	○ No
Visual Problems	Yes ○	○ No
Cardiovascular		
Shortness of Breath	Yes ○	○ No
Chest Pain	Yes ○	○ No
Palpitations	Yes ○	○ No
Respiratory		
Cough / Wheezing	Yes ○	○ No
Gastrointestinal		
Nausea and Vomiting	Yes ○	○ No
Diarrhea or Constipation	Yes ○	○ No
Genitourinary		
Burning on Urination	Yes ○	○ No
Blood in Urine	Yes ○	○ No
Incontinence of Urine	Yes ○	○ No
Musculoskeletal		
Muscle Weakness	Yes ○	○ No
Skin		
Skin rash or Lesion	Yes ○	○ No
Neurological		
Seizures	Yes ○	○ No
Numbness or Tingling	Yes ○	○ No
Psychiatric		
Depression / Anxiety	Yes ○	○ No
Hematology		
Easy Bruising	Yes ○	○ No
Unusual Bleeding	Yes ○	○ No

FOR OFFICE USE ONLY

Urologist: _____

Biopsy Date: _____

LEFT RIGHT



IIEF:

IPSS:

PSA: _____ | Prostate Volume: _____

DRE: _____ | Number of Total Past Biopsies: _____

Height: _____ | Weight: _____ | BMI: _____

Imaging:

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IIEF

NAME _____

DATE OF BIRTH AGE

ADDRESS

_____

TELEPHONE _____

Patient Questionnaire

These questions ask about the effects that your erection problems have had on your sex life over the last four weeks. Please try to answer the questions as honestly and as clearly as you are able. Your answers will help your doctor to choose the most effective treatment suited to your condition. In answering the questions, the following definitions apply:

- **sexual activity** includes intercourse, caressing, foreplay, & masturbation.
- **sexual intercourse** is defined as sexual penetration of your partner.
- **sexual stimulation** includes situation such as foreplay, erotic pictures, etc.
- **ejaculation** is the ejection of semen from the penis (or the feeling of this).
- **orgasm** is the fulfillment or climax following sexual stimulation or intercourse.

Over the past 4 weeks:

Q1	How often were you able to get an erection during sexual activity?	0 No sexual activity 1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q2	When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	0 No sexual activity 1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q3	When you attempted intercourse, how often were you able to penetrate (enter) your partner?	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q4	During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always

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Name

DOB

Q5	During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	0 Did not attempt intercourse 1 Extremely difficult 2 Very difficult 3 Difficult 4 Slightly difficult 5 Not difficult
Q6	How many times have you attempted sexual intercourse?	0 No attempts 1 One or two attempts 2 Three or four attempts 3 Five or six attempts 4 Seven to ten attempts 5 Eleven or more attempts
Q7	When you attempted sexual intercourse, how often was it satisfactory for you?	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q8	How much have you enjoyed sexual intercourse?	0 No intercourse 1 No enjoyment at all 2 Not very enjoyable 3 Fairly enjoyable 4 Highly enjoyable 5 Very highly enjoyable
Q9	When you had sexual stimulation or intercourse, how often did you ejaculate?	0 No sexual stimulation or intercourse 1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q10	When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?	1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q11	How often have you felt sexual desire?	1 Almost never or never 2 A few times (less than half of the time) 3 Sometime (about half of the time) 4 Most times (more than half of the time) 5 Almost always or always
Q12	How would you rate your level of sexual desire?	1 Very low or none at all 2 Low 3 Moderate 4 High 5 Very high
Q13	How satisfied have you been with your overall sex life?	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied
Q14	How satisfied have you been with your sexual relationship with your partner?	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied
Q15	How do you rate your confidence that you could get and keep an erection?	1 Very low or none at all 2 Low 3 Moderate 4 High 5 Very high

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ERNATIONAL PROSTATE SYMPTOM SCORE (IPSS)

NAME _____ DATE _____

The questionnaire below was developed by the American Urological Association (AUA) to help men evaluate the severity of their symptoms from benign hyperplasia (BHP). This self-administered test can help determine which treatment is needed, if any. Symptoms are classified as mild (1 to 7), moderate (8 to 19), or severe (20 to 35). Generally, no treatment is needed if symptoms are mild; moderate symptoms usually call for some form of treatment; and severe symptoms indicate that surgery is most likely to be effective.

Q1	Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0 Not at all 1 Less than 1 time in 5 2 Less than half the time 3 About half the time 4 More than half the time 5 Almost always
Q2	Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0 Not at all 1 Less than 1 time in 5 2 Less than half the time 3 About half the time 4 More than half the time 5 Almost always
Q3	Over the past month, how often have you found you stopped and started again several times when you urinated?	0 Not at all 1 Less than 1 time in 5 2 Less than half the time 3 About half the time 4 More than half the time 5 Almost always
Q4	Over the past month, how often have you found it difficult to postpone urination?	0 Not at all 1 Less than 1 time in 5 2 Less than half the time 3 About half the time 4 More than half the time 5 Almost always
Q5	Over the past month, how often have you had a weak urinary stream?	0 Not at all 1 Less than 1 time in 5 2 Less than half the time 3 About half the time 4 More than half the time 5 Almost always
Q6	Over the past month, how often have you had to push or strain to begin urination?	0 Not at all 1 Less than 1 time in 5 2 Less than half the time 3 About half the time 4 More than half the time 5 Almost always
Q7	Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0 None 1 One time 2 Two times 3 Three times 4 Four times 5 Five times
	TOTAL SCORE	
Q8	How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0 Delighted 1 Pleased 2 Mostly Satisfied 3 Mixed 4 Mostly Dissatisfied 5 Unhappy 6 Terrible

Source: American Urological Association

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Medivizor

We have partnered with Medivizor to help provide our patients personalized health information and updates, specifically for your medical situation. If you'd like to receive invitation to use this unique and new service (for free and completely HIPAA compliant and private), please fill in this form and return it filled in:

Personalized Health Information

Medivizor is a new, unique, and free health information service.

The service is already helping thousands of patients and caregivers cope with serious or chronic illness by providing them health information and subsequent updates tailored for each patient's particular situation.

Such information includes information about the medical condition, its treatment options, cutting-edge research, matching clinical trials, and more. All the information is based on the most credible sources and summarized briefly in high-school level English making it easy to understand and act upon.

Fill in your email address and the medical condition(s) of your interest to get invited by email. If your condition is not listed below, you may add it under "other" and Medivizor will notify you once it starts supporting it.

Your email address: _____

Select your condition(s):

- ☐ Benign prostatic hyperplasia
- ☐ Breast cancer
- ☐ Colorectal cancer
- ☐ Diabetes
- ☐ Erectile dysfunction
- ☐ Heart attack / coronary artery disease
- ☐ Hypertension
- ☐ Infertility
- ☐ Kidney stones
- ☐ Lung cancer
- ☐ Melanoma
- ☐ Prostate cancer
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Urinary incontinence
- ☐ Urinary tract infection

☐ Other: _____

☐ **Check this box to receive your private and free Medivizor invitation.**

To learn more: **www.medivizor.com**

For any help, please contact care@medivizor.com. Thanks!

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Email Consent Form

This consent authorizes Dr. Ash Tewari and his administrative/digital teams to communicate with you using open internet email channels.

This consent allows Dr. Ash Tewari and his administrative/digital teams to communicate with you using any email address that you provide.

You authorize Dr. Ash Tewari and his administrative/digital teams to send you emails regarding non-patient health information/updates. *Email frequency will be no more than once a month. Emails will not be used for solicitation of funds.*

You understand that you can "opt out" of these emails by replying, as such, to one of the emails you receive.

Patient Name: _____

Patient Email Address: _____

Patient Signature: _____

Date: _____

Icahn School of Medicine at Mount Sinai

Ash Tewari, MBBS, MCh, FRCS (Hon)
Professor and Chairman,
Milton and Carroll Petrie
Department of Urology

625 Madison Avenue, 2nd Floor
New York, NY 10022
T 212-241-9955
F 646-537-8508
ashtewari@mountsinai.org

Patient Medical Information Release Form

- Obtained upon initial registration (Pre consult) **(Front Desk)**
- Obtained Post consult **(Surgical Team)**
- Patient declined _____

Patient Name:	
Patient DOB:	

I hereby allow the release of my health information, studies, imaging, reports, and any other pertinent health material to Dr. Ashutosh Tewari, as requested by their office. Please release materials they request for my upcoming Robotic Prostatectomy as soon as possible.

Please feel free to reach out to the patient if additional information is required.

Please note that pathology glass slides must be released to the address below or be picked up personally.

ATTN: Dr. Ashutosh Tewari

625 Madison Avenue

2nd floor-Urology

NY, NY 10022

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

_____
Patient Name

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ *The patient refused to sign despite good faith efforts*
- ☐ *The patient was unaccompanied and not alert and oriented*
- ☐ *The patient was unaccompanied and needed emergency care*
- ☐ *Other,(explain)*: _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

- ☐ Acknowledgement subsequently obtained, (see above).

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Agreement to Receive Messages Containing PHI at Home

Name: _____

MRN: _____

I hereby authorize Dr. _____ or his/her designee to leave a message containing PHI necessary for my care

☐ On my answering machine at home or with anyone who answers my phone.

☐ At the following telephone number only.

Telephone Number: _____

Signature Patient: _____

Signature Personal Representative: _____

PRINT NAME: _____

Authority: _____

Date: _____

MR-225 (Rev 7/13)

Mount Sinai

Patient Name: _____

MRN: _____ Admit Date: ____/____/20____

Contact List/Instructions

To assist us in protecting your privacy please provide us with the names and contact numbers of no more than three people with whom we may discuss your care.

Category	Name	Relationship	Mobile phone #	Other Telephone #
People with whom Mount may share my health care status				
Designated Contact Person				

Other Instructions/Verification Code Word _____

Signature: _____ (Patient) or _____ (Personal Representative) Date: ____/____/ 20____

Individual processing form : _____ PRINT NAME: _____ Date: ____/____/ 20____

MR - 210 (4/13)

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CONSENT FOR COMMUNICATION VIA E-MAIL (Provider-Patient)

I, _____, hereby consent to have my physician, _____, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Email: _____

Signature: _____ Date: _____

MR-240 (7/13)