



Welcome to Mantality! Through our desire to provide you with the most focused and personalized experience, we would like to understand the primary reason that has brought you to the center. Please take a moment to identify which of the following you are hoping to achieve through your care:

(Please assign a numerical value from 1-5 to each goal in order of importance)

- Improved Energy
- Improved Physical Stamina/Endurance
- Weight Loss
- Improved Sex Drive
- Improved Sexual Function
- Hair Loss

Patient Information

How did you hear about us?

- Referral
- Internet
- KMOX
- 97.1
- ESPN
- McGraw Millhaven

Date: _____ Birth Date: _____ Age: _____ SSN: _____

Name: _____ E-mail: _____
Last First MI

- Single
- Married
- Divorced
- Other

Street Address: _____ Home Phone: (____)____-_____

City: _____ State: ____ Zip: _____ Cell Phone: (____)____-_____

(We will not send you any other text messages without your prior approval)

Place of Employment: _____ Work #: (____)____-_____

Work Address: _____ City: _____ State: _____ Zip: _____

Primary Doctor: _____ Phone Number: (____)____-_____

Policy Holder Information *(If different than yourself)*

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship: _____ Date of Birth: _____

SSN: _____ Home Phone: (____)____-_____

Employer: _____ Cell Phone: (____)____-_____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

- 0 = would *never* doze or sleep.
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Name: _____ Date: _____
 Last First MI

<i>Situation</i>	<i>Chance of Dozing or Sleeping</i>
Sitting and Reading	
Watching T.V.	
Sitting Inactive in a Public Place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic	
Total Score	

Cardiopulmonary/Upper Airway Findings:

BMI: _____

Neck Circumference: _____

Venous Disease Screening Assessment

(Check the Appropriate Box)				
Vascular History: do you have or have you ever been diagnosed with:				
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Pleuritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Deep Vein Thrombosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Saphenous Vein Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Do you experience any of the following in your leg(s):				
Aching/Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Heaviness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Tiredness/Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Itching/Burning	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Restless Legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Throbbing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Skin or Ulcer Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Which of the following do you currently do to improve your leg symptoms?				
Medication for pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What?	
Elevation of legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What?	
Wear support hose	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What?	
Family History: have you ever been treated for varicose veins with:				
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Vein Stripping	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Blood Coagulation Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Stroke, Heart Attack, or Pulmonary Embolism	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Vein Treatment History: have you ever been treated for varicose veins with:				
Sclerotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Laser Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Phlebectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Vein Stripping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
RF Ablation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
Personal Activities List: do you or have you had to:				
Stand for prolonged periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Sit for prolonged periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Exercise Regularly	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Smoke	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Have you ever been pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many times:	

Patient History Questionnaire (check Yes or No)		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any muscle weakness, fatigue or less of muscle mass?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has your interest in sex (libido) declined?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have spontaneous erections (without medication or aid)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has your energy or stamina declined?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you lost self confidence, motivation or initiative?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has there been any decline in memory or concentration ability?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any sleep disturbance or problems breathing while asleep?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have mood swings or depression?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you noticed any increase in aggressiveness?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any breast tenderness or enlargement?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you lost any hair in the genital or underarm areas?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has your need to shave decreased?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you noticed any significant change in the size of your testicles?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have periodic hot flashes or sweats?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had problems achieving a pregnancy?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you considering having any (or more) children?
Family History (check Yes or No)		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any blood related family members with breast cancer?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any blood related family members with prostate cancer?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any blood related family members with diabetes?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any blood related family members with cardio vascular disease?
Social History (check Yes or No)		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use tobacco? If yes, how many packs per day: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you drink alcoholic beverages? If yes, how much and how often: _____
Past History (check Yes or No)		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had an abnormal PSA test or prostate exam? Explain: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have or have you ever had: _____ Thyroid Disease. Explain: _____ _____ Diabetes. Explain: _____ _____ High Blood Pressure. Explain: _____ _____ Asthma/Lung Disease. Explain: _____ _____ Acne, Dry or Oily Skin. Explain: _____ _____ Venereal Disease. Explain: _____

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you currently take any medications? If so, list below				
		Medication	Dose	How Often	Reason	Prescribing M.D.

Patient Signature: _____

Date: _____

Review of Systems

Please check all that apply.

Ears, Nose and Throat:

- Hearing Loss
- Ringing in Ears
- Altered Sense of Smell
- Trouble Swallowing
- Neck Pain/Stiffness

Gastrointestinal System:

- Pain with Swallowing
- Abdominal Pain
- Nausea
- Vomiting

Lungs:

- Nonproductive Cough
- Pain with Breathing at Rest
- Pain with Breathing with Exertion
- Pain with Inspiration
- Wheezing
- Coughing up Blood
- Short of Breath with Exertion

Cardiovascular System:

- Chest Pain/Pressure at Rest
- Chest Pain/Pressure with Exertion
- Heart Palpitations
- Normal Tolerance to Exercise
- Pain in legs with Walking
- Cold Hands/Feet
- Fainting
- Light headedness

Hematology (Blood):

- Anemia
- Hemochromatosis

Allergic:

- Hives

Neurological System:

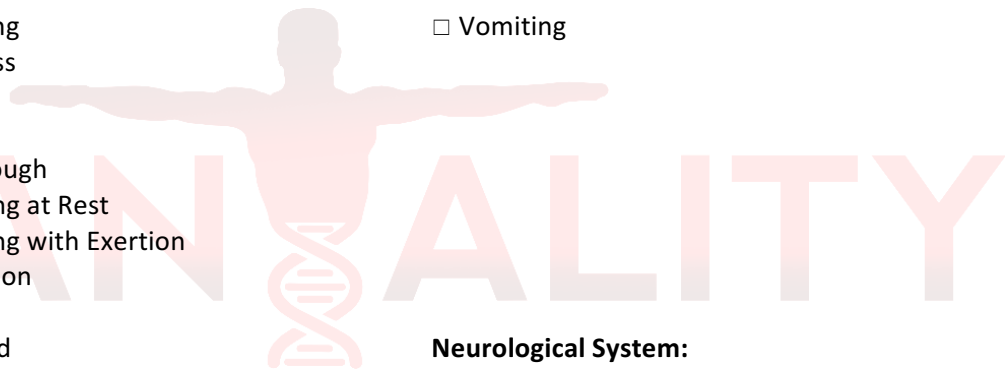
- Headache
- Loss of Sensation in any part of the body
- Weakness of any extremity
- Uncontrolled Muscle Movements
- Dizziness
- Problems with walking
- Speech Disturbance

Genitourinary System:

- Pain with Urination
- Urinary Frequency
- Urinary Urgency
- Blood in Urine
- Trouble Starting Stream
- Difficulty Stopping Stream
- Erectile Dysfunction

Musculoskeletal System:

- Joint Pain (any joint)



- Pain in any muscles
- Muscle weakness

- Depressed

General Constitution:

- Fatigue
- Night Sweats
- Weight Loss
- Weight Gain

Endocrine:

- Goiter
- Appetite Change
- Heat or Cold intolerance

Integumentary (Skin) System:

- Rashes

Eyes:

- Headache
- Blurry Vision
- Double Vision
- Visual Changes

Psychiatric:

Comments:

Physician Signature: _____

Date: _____

AUA Symptoms Score (AUASS) and Quality of Life (QQL)

Patient Name: _____

Today's Date: _____

(Circle One Number on Each Line)	Not at All	Less than 1 time in 5	Less than Half the time	About Half the time	More than Half the time	Almost Always
Over the past month of so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month of so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 Times

Over the past month, how many times per night 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	1	2	3	4	5
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Add the Score for each number above and write the total here:

Total: _____

Symptom Score: 1-7 (Mild)

8-19 (Moderate)

20-35 (Severe)

Quality of life (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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?							

Thank you for filling out Mantality's Questions!

