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?
Referall Internet Radio Other

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: (____)____-______

<u>Epworth Sleepiness Scale</u>

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

Situation	*Chance of Dozing or Sleeping*
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:** _______________

MANUALITY

Venous Disease Screening Assessment

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

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

☐ Yes	☐ No	Do you currently take any medications? If so, list below

Medication	Dose	How Often	Reason	Prescribing M.D.

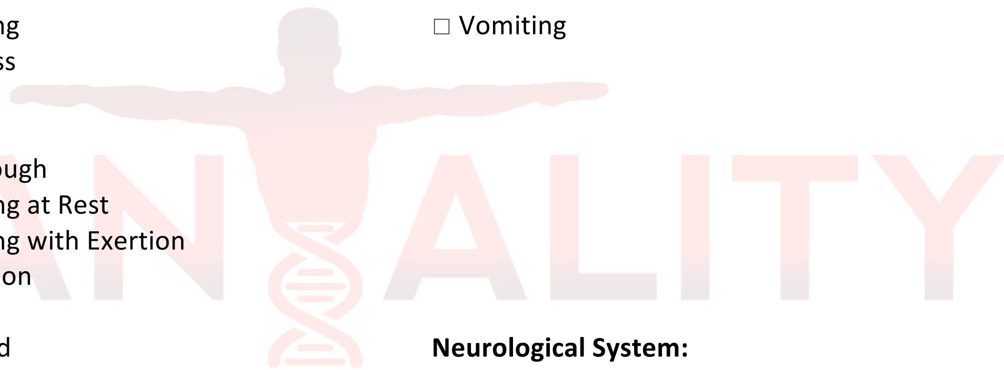
Patient Signature: _________________________________ Date: _____________

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

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

Gastrointestinal System:
☐ Pain with Swallowing
☐ Abdominal Pain
☐ Nausea
☐ Vomiting

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

General Constitution:
☐ Fatigue
☐ Night Sweats
☐ Weight Loss
☐ Weight Gain

Integumentary (Skin) System:
☐ Rashes

Psychiatric:
☐ Depressed

Endocrine:
☐ Goiter
☐ Appetite Change
☐ Heat or Cold intolerance

Eyes:
☐ Headache
☐ Blurry Vision
☐ Double Vision
☐ Visual Changes

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

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!