John G. Pattaras, MD, FACS
Associate Professor of Urology
Director of Minimally Invasive Surgery
404-778-4898 Appointments
404-778-8377 Audrie Thomas
678-843-6693 Fax

Department of Urology
5673 Peachtree Dunwoody Road Suite 350A
Atlanta, GA 30342

To all new patients of Dr. John Pattaras:

I am pleased to receive your consideration for your urological healthcare needs and I look forward to your upcoming visit. I wanted to take just a few moments to briefly orient you to my practice and to provide you some information that should be helpful for your upcoming visit.

I am a Board Certified Urologist who after completing my urologic surgery residency, I spent two years of additional fellowship in cancer research and endoscopy/laparoscopy. I am an Associate Professor in the Department of Urology at Emory University and the Director for the Minimally Invasive Urologic Surgery program. I am also the Director of Emory Urology at our Emory Saint Joseph's campus and have been teaching at the University since 2000.

As you might anticipate, my practice focuses on minimally invasive surgery. This means I typically perform robotic, laparoscopic and endoscopic surgery. **Laparoscopic or Robotic** surgery involves placing scopes into the abdomen through small half or quarter inch incisions to remove cancer, to perform reconstructive surgery and biopsies. **Endoscopic** surgery is a procedure, which uses small scopes to operate. These scopes can be used to operate on the kidney, ureter, bladder, or prostate stones, blockages and tumors. While endoscopy, laparoscopy and kidney stone disease are my areas of practice; I do see patients for a certain general urology needs.

In an effort to ensure the accuracy of our records and the prompt delivery of your care, let me ask that you carefully review the following items.

1. **Fully complete your medical history form** – To the best of your knowledge, we ask that you fully complete your medical history form. Remember to answer the section on medications (including making note of aspirin or over-the-counter medications you may be taking). We also need to know about all prior surgeries and any medication allergies you may have (indicate "None" if do not suffer from allergies). Please do not skip sections unless you need to discuss your answers with me.

2. **Personally deliver any pertinent medical records** – We ask that you email (or patient portal) or personally bring all pertinent medical records to your office visit, including lab results, x-rays (CT and MRI scans on **computer disk** is preferable), reports, and physician office notes (if necessary). Do not assume that your referring doctor's office will fax the records to our office. Delays in receiving pertinent records could necessitate the rescheduling of your appointment.

   I personally like to review each of the actual films because it can make a significant difference in the handling of your care. A report itself can be misleading or read wrong.

3. **Obtain your primary care physician's referral** – If your insurance company requires a referral, please obtain the referral from your primary care physician before your visit with me. If referrals are not obtained, your appointment will be rescheduled.

4. **Clearance for surgery from a Cardiologist (or Primary Care Physician)** – If you are being referred for surgery or you suspect you may require surgical treatment, please be aware that a written clearance must be obtained from your cardiologist if you have a heart problem or a history of heart problems. This means that an EKG or a stress test will likely be necessary. Please make sure that an appointment date with your cardiologist is scheduled well in advance of your potential surgery date. Please make the cardiologist aware of the upcoming surgery so suggestions of stopping certain medications or aspirin are addressed. If you are in need of a medical or cardiac evaluation and are not aware of a physician that could assist you, we will be happy to assist in finding an appropriate Emory physician.

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5. **Promptness is Important** – As you may know, traffic in Atlanta is a tremendous problem and can easily create lengthy travel delays. In addition, parking spaces may be challenging to find promptly. We have a valet parking service to assist with this, but if you are seeking your own parking space, please take into consideration that this may cause further delay. Therefore, please make your travel plans with the intention of arriving 20-30 minutes early as check-in, a urine specimen and any needed paperwork will be completed. Due to our very tight appointment schedule, patients arriving 20 minutes after their scheduled appointment will try and be worked in but may need to be rescheduled as this is unfair to patients arriving on time.

6. **Tests and Studies following your visit with me** – After you visit with me, laboratory tests and additional studies may be ordered. Blood tests and simple X-rays will very likely be performed on the same day of your visit with me. However, complicated studies (such as CT's or MRI's) will be scheduled with the Radiology Department and could take several weeks to complete.

7. **Preparations for Procedures** – If you are scheduled to have a procedure during your visit with me, please make sure you understand what preparations are required prior to the procedure. Biopsies and minor surgical procedures require that you stop taking **aspirin** or other types of pain medication (NSAID's) 10 days prior to the procedure. Some procedures require enemas or colon cleansings.

8. **Receiving results from biopsies or lab tests** - If biopsies or lab tests are performed, it is routine that a follow-up appointment is made to discuss these results if concerning. Results are not given over the telephone unless authorized by me. Office assistants and nurses cannot discuss certain results over the phone when there are complicated explanations. PSA (prostatic specific antigen) and blood test results will be mailed from our office with a little note.

9. **Returning routine office calls** – Routine office calls will be returned in a timely fashion. Due to the office/surgery/research schedule and patient volume that I keep, this typically means I will return calls on Monday & Friday afternoons or evenings, unless of course your call actually involves an emergency circumstance.

I appreciate the time you have taken to familiarize yourself with my practice and I hope that you have found it to be helpful. Audrie Thomas (404-778-8377) can help schedule or assist in preparation in visits and surgery. Once again, I look forward to meeting you and please do not hesitate to contact my office if you should have any questions prior to your visit.

Cordially,

John G. Pattaras, M.D., F.A.C.S.

Directions to Emory Urology at St. Joseph's - 5673 Building

Emory Saint Joseph's Hospital is located just inside the perimeter next to the Medical Center Marta Station. Urology at St. Joseph's is located at **5673 Peachtree Dunwoody Road, NE, Suite 350-A, Atlanta, GA, 30342.** This is the doctors' office building located on the far left side of the campus when you come in through the main entrance on Peachtree Dunwoody Road.

Directions

•Take I-85 North to GA 400 (exit 87). Take exit 3 (Glenridge Connector) and turn right (Glenridge Rd.). Go to the second light and turn left (Peachtree Dunwoody Rd.). Go through the next light (Johnson Ferry Rd.) and immediately enter the far right-hand lane. Turn right into the hospital campus.

From Marietta, Smyrna, Chattanooga

•Take I-75 South to I-285 East. Take exit 26 (Glenridge Connector). Turn right at the end of the ramp (Glenridge Rd.). Immediately enter the far left-hand lane. At the first light, turn left (Johnson Ferry Rd.). At the third light, turn left (Peachtree Dunwoody Rd.) and immediately enter the far right-hand lane. Turn right into the hospital campus.

From Roswell, Alpharetta, Cumming, Dahlonega

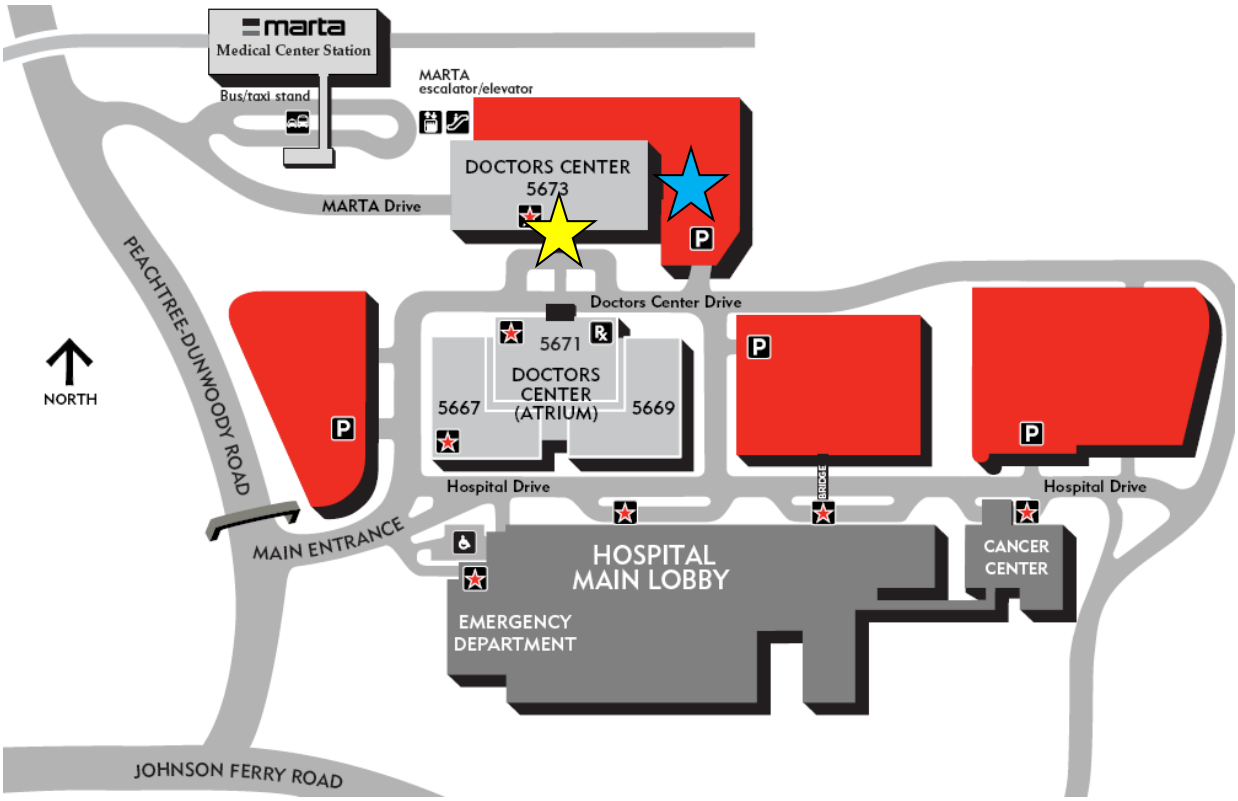
•Take GA 400 South to exit 3 (Glenridge Connector) and turn right (Glenridge Rd.). Go the second light and turn left (Peachtree Dunwoody Rd.). Go through the next light (Johnson Ferry Rd.) and immediately enter the far right-hand lane. Turn right into the hospital campus.

From Birmingham and all points west of the hospital

•Take I-20 East to I-285 North (past I-75) and take exit 26 (Glenridge Connector). Turn right at the end of the ramp (Glenridge Rd.). Immediately enter the far left-hand lane. At the first light, turn left (Johnson Ferry Rd.). At the third light, turn left (Peachtree Dunwoody Rd.) and immediately enter the far right-hand lane. Turn right into the hospital campus.

From Augusta and all points east of the hospital

•Take I-20 West to I-285 North (past I-85, I-285 will become West). Got to Exit 28 (Peachtree Dunwoody Rd.) and turn left. At the third traffic light, just past the MARTA station, turn left into the hospital grounds.



The patient parking deck is located behind the 5673 Building, indicated by the blue star.

5673 Building is indicated by the yellow star. Urology is located on the third floor in suite 350.

EMORY
HEALTHCARE

EMORY UNIVERSITY HOSPITAL
THE EMORY CLINIC
EMORY UNIVERSITY HOSPITAL MIDTOWN
EMORY UNIVERSITY ORTHOPAEDICS & SPINE HOSPITAL
EMORY CHILDREN'S CENTER
WESLEY WOODS GERIATRIC HOSPITAL
BUDD TERRACE
EMORY DIALYSIS, LLC
EMORY SPECIALTY ASSOCIATES
WESLEY WOODS LONG TERM ACUTE CARE HOSPITAL
EMORY JOHNS CREEK HOSPITAL
EMORY SAINT JOSEPH'S HOSPITAL
EMORY UNIVERSITY HOSPITAL SMYRNA

Admission/Registration Agreement

USE THIS AREA FOR STAMP OR LABEL WITH PATIENT INFORMATION

I. **CONSENT FOR TREATMENT:** I consent to such routine diagnostic and treatment procedures/examinations and laboratory procedures considered reasonably necessary for the care and treatment of my condition during my admission to an Emory Healthcare Hospital or my outpatient care at an Emory Healthcare facility. I understand that diagnostic and treatment procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I understand that Emory Healthcare's mission includes training physicians and other medical personnel and conducting medical research. I acknowledge that students may participate in my care. If I am asked to participate in a research study, I may refuse to participate and my refusal will not affect or compromise my access to medical services.

II. **INDEPENDENT CONTRACTORS:** I understand that some of the health care professionals providing care, treatment and services at the Emory Healthcare Hospitals or facilities are independent contractors, and are not agents or employees of the Hospitals or Emory Healthcare. Independent contractors are responsible for their own actions and neither the Hospitals nor Emory Healthcare shall be liable for the acts or omissions of any such independent contractors.

III. **ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT AND APPOINTMENT OF REPRESENTATIVE:** If I am entitled to benefits under the Medicare program, the Medicaid program, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for admission to and for services provided to me by an Emory Healthcare facility, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered during my admission to the Emory Healthcare facilities that provide services to me. I authorize payment of benefits directly to such Emory Healthcare facilities,with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not precertified or not preauthorized by my insurance plan.**

If my health care benefits are provided under a self-funded plan under the Employee Retirement Income Security Act - (ERISA), in order to assist me in obtaining my benefits: I authorize and appoint Emory Healthcare to act as my representative, when Emory Healthcare consents in writing to so act, in appealing any adverse benefit determination and to receive notices on my behalf with respect to same. I agree that I will comply with procedures established by my benefit plan relating to this authorization, if any.

IV. **PERSONAL VALUABLES:** I understand that Emory Healthcare Hospitals and Budd Terrace maintain a safe for patient money and valuables and that neither the Hospitals *nor* Budd Terrace nor any Emory Healthcare facility shall be legally responsible for the loss of or damage to any money, jewelry, glasses, hearing aids, dentures, documents or other articles of value, unless deposited with Emory Healthcare staff for safekeeping.

V. **CONSENT FOR DISCLOSURE OF INFORMATION:** I understand the Emory Healthcare facilities are permitted to disclose protected health information about me for purposes of payment, my continued care or treatment, and healthcare operations. If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse and/or mental illness, I hereby consent to the disclosure of this information by the Emory Healthcare facilities only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I understand this consent permits release of the identified information to any insurance company, healthcare plan or any other person or entity financially responsible for my treatment if necessary for purposes related to filing a claim for payment, or, if I am being evaluated for a transplant, for purposes of determining eligibility, and to my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, government or private agency which may provide medical, mental health, rehabilitation, social or related services to me during or upon my discharge or transfer from an Emory Healthcare facility.

I understand my consent to disclosure of information related to treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse, or mental illness is valid until all bills related to my treatment have been paid and utilization and/or quality assessment have been completed. I further understand I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

VI. **AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION:** I agree that any claim or dispute arising out of or related to the provision of health care services to me by Emory University, Inc. d/b/a Emory University Hospital, Emory University Orthopaedics & Spine Hospital and Emory University Hospital Midtown; The Emory Clinic, Inc. (and the Ambulatory Surgery Center); Emory Healthcare, Inc.; Emory Children's Center, Inc.; Wesley Woods Long Term Acute Care Hospital; Wesley Woods Center of Emory University, Inc. (Wesley Woods Geriatric Hospital and Budd Terrace); Emory Johns Creek Hospital, or their employees or agents ("Emory"), except as otherwise provided herein, shall be resolved by final and binding arbitration. I agree that this provision is governed by the terms of the Federal Arbitration Act. I understand and agree that this agreement includes and encompasses any claims arising out of or relating to health care services which shall be provided to me upon this admission as well as all health care services provided to me by Emory in the future, provided, however, that this agreement does not include and encompass any claim or dispute by either party arising out of or related to the billing or payment for health care services. I understand and agree that by agreeing to arbitrate, I am waiving my right to a jury trial (if otherwise available). I understand that this agreement is also binding on any individual or entity claiming by or through me or on my behalf. I understand that this agreement is voluntary and is not a precondition to receiving health care services. The arbitration of any claim or dispute hereunder shall be conducted in the State of Georgia in accordance with the Rules and Procedures of Henning Arbitration and Mediation Services, Inc., a copy of which is available to me upon request. I understand that I have the right to revoke this agreement no later than ten (10) days following signature and that, if I choose to revoke, I must request and execute a revocation form within this time period.

NOTE: If the individual signing this agreement is doing so on behalf of his or her minor child or any other person for whom he or she is legally responsible, the signature below affirms that he or she has the authority or obligation to contract with Emory for the provision of health care services to that minor child or other person, and that his or her execution of this agreement is in furtherance of that authority or obligation.

DATE: _____ _____

PATIENT, PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE

VII. **PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS:** I understand that the physicians or staff at certain of the Emory Healthcare facilities may request to take photographs, videotapes or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care or treatment purposes, and I consent to being photographed, videotaped, or recorded for these purposes. I further acknowledge that such photographs, videotapes, recordings, and related information may be used for internal operations purposes of Emory Healthcare, including, but not limited to medical education, training programs, quality assessment and improvement activities, outcomes evaluation, case management, and related functions that do not include treatment. I understand that such photographs, videotapes and recordings will be maintained in a secure manner and will not be disclosed for external use, except upon written authorization from me or my authorized representative or as required or permitted by law.

VIII. **HOSPITAL PATIENT DIRECTORY:** If I am a hospital patient, I understand the following information will be included in the Hospital Directory – my Name, my Room Number/Location, my General Condition such as Fair, Stable or Critical, and my Religious Affiliation (if expressed). I understand that my location in the hospital and my general condition will be provided to persons who inquire about me by name, and that my religious affiliation along with the other directory information will be provided to members of the clergy who request information on patients based on their religious affiliation. Patients in an Emory Healthcare Mental Health Unit are not included in the Hospital Directory.

If you are a hospital patient and do not want your information included in the Hospital Directory, please check Opt-Out of Hospital Directory below and initial.

- I Opt Out of the Hospital Directory _____ *(please initial)*

IX. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received the Emory Healthcare Notice of Privacy Practices. _____ *(please initial)*

X. **MEDICATIONS ASSISTANCE PROGRAM:**

In some cases, the hospital is able to obtain reimbursement for some of your medications from companies that manufacture them. When this occurs, the cost of the medication is removed from the charges on your hospital stay. Most of these programs require your signature on the applications forms. So that you do not have to sign this application for each medication, we are requesting that you allow a Pharmacy Healthcare Solutions ("PHS") representative to sign these forms on your behalf.

I appoint PHS to carry out in my name, the application forms required for PHS to obtain replacement of my medications from pharmaceutical manufacturers. This document will be in full force from the date signed.

The date of this Admission Agreement is (insert today's date) _____ Time _____

_____ _____

Witness Signature of Patient or Patient's Representative

_____ _____

Relationship of Representative to Patient

_____ _____

Interpreter name/operator number Date

EMORY UNIVERSITY SCHOOL OF MEDICINE | Department of Urology

Place label here

History & Physical Form for New & Pre-Operative Patients

Who referred you to Emory Urology?	Who provides your Primary Care?	What is your home Pharmacy?
Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Address: _____
_____	_____	_____
Phone: (_____) - _____ - _____	Phone: (_____) - _____ - _____	Phone (____) - ____ - _____
Fax: (_____) - _____ - _____	Fax: (_____) - _____ - _____	Fax: (_____) - ____ - _____

What is the reason for your visit today? _____

Communication

Would you like to communicate with us via Patient Portal? No [ ] Yes [ ]

Would you allow us to communicate health information with you via email or phone? No [ ] Yes [ ]

- Email _____ - Cell phone _____

Please bring copies of your medical records and/or CD with images with you to your appointment

HISTORY OF PRESENT ILLNESS *(HPI: L2-L3=1-3, L4-L5=4)*

Location of problem:_____ Date your condition first appeared:_____

Character of Pain (if experiencing):_____ Severity: (None) 1 2 3 4 5 6 7 8 9 10 (Worst)

Duration: _____ Timing: ☐ Improving ☐ Worsening ☐ Stable ☐ Other _____

Associated/Alleviating/Aggravating Symptoms: _____

BELOW SPACE FOR PROVIDER USE ONLY

PATIENT MEDICAL HISTORY *(PMH/FH/SH: L1-L2=0, L3=1/3, L4-L5=3/3)*

Do you now, or have you ever had, the following conditions?

☐ Diabetes ☐ Hypertension ☐ COPD ☐ Asthma ☐ Sleep Apnea ☐ Liver Disease ☐ Anemia
☐ Stomach Ulcers ☐ Bleeding problems ☐ Clotting problems ☐ Blood clot ☐ Stroke ☐ CHF
☐ Heart Attack ☐ Bypass surgery ☐ Heart valve ☐ Cardiac Stents ☐ Congenital heart disease
☐ Kidney Stones ☐ High cholesterol ☐ Prostate problems ☐ Bladder problems ☐ Irregular heart rhythm
☐ Cancer (type)_____ ☐ **Severe Allergic Reaction**:_____
☐ Other_____

HOSPITALIZATION / SURGERIES (Please list all hospitalizations, procedures and surgeries)

Month / Year	Surgery? If yes, list type of surgery you had	Reason

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Place label here

FAMILY MEDICAL HISTORY

Does anyone **in your family** have the following? **Specify relationship** and **age** at time of problem.

☐ Heart problems_____ ☐ Prostate Cancer_____
☐ Kidney problems_____ ☐ Bladder Cancer_____
☐ Bladder problems _____ ☐ Kidney Cancer_____
☐ Blood clots in legs or lungs_____ ☐ Other Cancer_____
☐ Bleeding/clotting disorders_____ ☐ Other _____

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced If you have children, how many ? _____
Occupation (Or prior occupation)/ Retired?:_____
How far from Emory do you live? _____

SUBSTANCES: Check (√) whether current or past use of the following substances.

Substance	Never	Current	Past	Amount per day
Caffeine				
Tobacco				Total # yrs: If quit, when?
Alcohol				
Street Drugs				

REVIEW OF SYSTEMS

(ROS: L2=1, L3=2, L4 -5= ≥10 systems)

Check (√) any *persistent* symptoms you currently have or have had in the PAST YEAR.

CONSTITUTIONAL
☐ Change in appetite
☐ Chills
☐ Dizziness
☐ Fever
☐ Headache
☐ Weight loss
☐ Weight gain
☐ **No problems**

SKIN / BREAST
☐ Itching
☐ Change in moles
☐ Skin rash
☐ Scars
☐ Breast lump/tenderness
☐ **No problems**

EYES
☐ Visual changes
☐ Blurred/Double vision
☐ Pain
☐ **No problems**

EAR, NOSE, THROAT
☐ Hearing problems
☐ Nosebleeds
☐ Bleeding gums
☐ Difficulty swallowing
☐ **No problems**

RESPIRATORY
☐ Difficulty breathing
☐ Asthma
☐ Cough up blood
☐ Shortness of breath
☐ **No problems**

CARDIOVASCULAR
☐ Chest pain /pressure
☐ Heart murmur
☐ Irregular heartbeat
☐ Leg pain with activity
☐ Breathless with activity
☐ **No problems**

GASTROINTESTINAL
☐ Change in bowel habits
☐ Constipation
☐ Persistent diarrhea
☐ Indigestion / heartburn
☐ Persistent nausea
☐ Vomiting
☐ **No problems**

ENDOCRINE
☐ Heat/Cold Intolerance
☐ Excessive urination
☐ Excessive thirst
☐ Excessive sweating
☐ **No problems**

GENITOURINARY
☐ Blood in urine
☐ Frequent urination
☐ Painful urination
☐ Difficulty urinating
☐ Foul odor to urine
☐ Straining to start urination
☐ **No problems**

(Men Only)
☐ Erectile dysfunction
☐ Hard lump in testicles
☐ Penis discharge
☐ Curve in penis
☐ **No problems**

(Women Only)
☐ Abnormal PAP smear
☐ Bleeding between periods
☐ Painful intercourse
☐ Vaginal discharge
Date of last period:_____
Are you pregnant?
☐ Yes ☐ No

NEUROLOGIC:
☐ Seizures
☐ Fainting / Syncope
☐ Need walker or cane
☐ **No problems**

MUSCULOSKELETAL
Pain, weakness, numbness, swelling, or redness in:
☐ Shoulders
☐ Hands
☐ Back
☐ Hips
☐ Feet
☐ **No problems**

HEMATOLOGIC/LYMPH
☐ Unusual Bleeding
☐ Blood clots
☐ Swelling on your body
☐ **No problems**

ALLERGIC/IMMUNE
☐ Non-Medical allergies
☐ Latex allergy
☐ Rashes
☐ **No problems**

PSYCHIATRIC
☐ Sleep disturbances
☐ Anxiety
☐ Depression
☐ **No problems**

OTHER SYMPTOMS:

REVIEWED BY MD: _____ DATE: ____/____/____

7582212412

DEPARTMENT OF UROLOGY

THE EMORY CLINIC

51

EMORY

Todays Date: ☐☐ / ☐☐ / ☐☐☐☐

Name:

PATIENT STICKER
(for office use)

rev 05/10/2007

(Bubble in 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
INCOMPLETE EMPTYING Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
FREQUENCY During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
INTERMITTENCY 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
URGENCY During the past month or so, how difficult have you found it to postpone urination?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
WEAK STREAM During the past month or so, how often have you had a weak urinary stream?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
STRAINING Over the past month, 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 or More Times**
NOCTURIA Over the past month, how many times did you most typically get up to urinate from the time you went to bed 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 in the space to the right: _____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

Expanded Prostate Cancer Index Composite for Clinical Practice (EPIC-CP)

A Clinical Tool to Measure Urinary, Bowel, Sexual and Vitality/Hormonal Health **Date:** ___ /___ /___

Patients: Please answer the following questions by checking the appropriate checkbox. All questions are about your health and symptoms in the **LAST FOUR WEEKS**. Select one answer for each question.

1. Overall, how much of a problem has your urinary function been for you?

☐ No problem ☐ Very small problem ☐ Small problem ☐ Moderate problem ☐ Big problem

2. Which of the following best describes your urinary control?

0 ☐ Total control 1 ☐ Occasional dribbling 2 ☐ Frequent dribbling 4 ☐ No urinary control ____

3. How many pads or adult diapers per day have you been using for urinary leakage?

0 ☐ None 1 ☐ One pad per day 2 ☐ Two pads per day 4 ☐ Three or more pads per day ____

4. How big a problem, if any, has urinary dripping or leakage been for you?

0 ☐ No problem 1 ☐ Very small problem 2 ☐ Small problem 3 ☐ Moderate problem 4 ☐ Big problem ____

*CLINICIANS: ADD the answers from questions **2-4** to calculate the **Urinary Incontinence Symptom Score (out of 12):*** ☐

5. How big a problem, if any, has each of the following been for you?

	No problem	Very small problem	Small problem	Moderate problem	Big problem	
a. Pain or burning with urination	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____
b. Weak urine stream/incomplete bladder emptying	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____
c. Need to urinate frequently	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____

*CLINICIANS: ADD the answers from questions **5a-5c** to calculate the **Urinary Irritation/Obstruction Symptom Score (out of 12):*** ☐

6. How big a problem, if any, has each of the following been for you?

	No problem	Very small problem	Small problem	Moderate problem	Big problem	
a. Rectal pain or urgency of bowel movements	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____
b. Increased frequency of your bowel movements	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____
c. Overall problems with your bowel habits	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____

*CLINICIANS: ADD the answers from questions **6a-6c** to calculate the **Bowel Symptom Score (out of 12):*** ☐

7. How would you rate your ability to reach orgasm (climax)?

0 ☐ Very good 1 ☐ Good 2 ☐ Fair 3 ☐ Poor 4 ☐ Very poor to none ____

8. How would you describe the usual quality of your erections?

0 ☐ Firm enough for intercourse 1 ☐ Firm enough for masturbation and foreplay only 2 ☐ Not firm enough for any sexual activity 4 ☐ None at all ____

9. Overall, how much of a problem has your sexual function or lack of sexual function been for you?

0 ☐ No problem 1 ☐ Very small problem 2 ☐ Small problem 3 ☐ Moderate problem 4 ☐ Big problem ____

*CLINICIANS: ADD the answers from questions **7-9** to calculate the **Sexual Symptom Score (out of 12):*** ☐

10. How big a problem, if any, has each of the following been for you?

	No problem	Very small problem	Small problem	Moderate problem	Big problem	
a. Hot flashes or breast tenderness/enlargement	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____
b. Feeling depressed	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____
c. Lack of energy	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	____

*CLINICIANS: ADD the answers from questions **10a-10c** to calculate the **Vitality/Hormonal Symptom Score (out of 12):*** ☐

*CLINICIANS: Add the five domain summary scores to calculate the **Overall Prostate Cancer QOL Score** (out of 60):* ☐