

San Diego Sexual Medicine

PATIENT REGISTRATION

Your paperwork must be completed upon arrival for your appointment.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_
First Middle Last

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_

Marital Status Single \_ Married \_\_\_ Widowed \_\_\_ Sex Female \_\_\_ Male \_\_\_

Mailing Address Street \_\_\_\_\_
City/State \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Phone(s) (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Preferred number: 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) \_\_\_\_\_

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.

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  
6719 Alvarado Road, Suite 108  
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 prior 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 Number

_____	_____
Signature	Date

San Diego Sexual Medicine

AUTHORIZATION FOR RELEASE OF RECORDS

To: San Diego Sexual Medicine  
Irwin Goldstein, MD  
Mary M. Clark, PhD  
6719 Alvarado Road, Suite 108  
San Diego, CA 92120  
Phone: 619 265-8865  
Fax: 619 265-7696

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the release of my medical records, which should include:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I request that these records be sent to:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's 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

Information regarding referring physician:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

I would like Dr. Goldstein to send detailed information regarding my visit to my referring physician.

- Yes  No

Information regarding primary care physician:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

I would like Dr. Goldstein to send detailed information regarding my visit to my primary care physician.

- Yes  No

San Diego Sexual Medicine

MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Married \_\_\_\_\_ yrs  Monogamous Relationship \_\_\_\_\_ yrs  Divorced  Single  Widowed

Major childhood illnesses: \_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_ Drug allergies: \_\_\_\_\_

Food allergies \_\_\_\_\_ Latex allergy: \_\_\_\_\_

Have you ever had any of the following medical conditions? (Check all that apply)

- Hypertension  Diabetes
 Heart Disease  Neurologic disease (e.g. MS)
 Stroke  Asthma
 High Cholesterol  Incontinence
 Thyroid problems  Genital conditions \_\_\_\_\_

Family history of any of the above conditions:

- Hypertension  Thyroid problems
 Heart Disease  Diabetes
 Stroke  Neurologic disease (e.g. MS)
 High Cholesterol  Asthma
 Urinary tract disease  Incontinence

Cancer: Type \_\_\_\_\_ Treatments: \_\_\_\_\_

Previous surgeries: Type and Date \_\_\_\_\_

Other medical disorders: \_\_\_\_\_

Depression  Other psychological disorders: \_\_\_\_\_

Current smoker? Y / N \_\_\_\_\_ yrs Have you ever smoked? Y / N \_\_\_\_\_ packs/day

Do you ever drink alcohol? Y / N \_\_\_\_\_ drinks/day

Do you use any recreational drugs (marijuana, cocaine, heroin, etc.): Y / N

Please describe: \_\_\_\_\_

Military service  Criminal history \_\_\_\_\_

Have you ever had any of the following medical conditions? (Check all that apply)

- Genitourinary conditions  Interstitial cystitis
 Urinary tract infection  Cervical dysplasia
 Abnormal vaginal or urethral discharge  Perineal trauma
 Sexually transmitted disease  Endometriosis
 Yeast infections  Vestibular adenitis
 Ovarian conditions  Breast conditions

**MEDICAL HISTORY page 2**

Age of first menstruation: \_\_\_\_\_ Are menses regular? Y / N  
Pain with menstruation? Y / N No. of days in cycle: \_\_\_\_\_  
No. of pregnancies: \_\_\_\_\_ Dates: \_\_\_\_\_  
Deliveries: Vaginal \_\_\_\_\_ Cesarean \_\_\_\_\_ Miscarriage: \_\_\_\_\_ Abortion: \_\_\_\_\_ Episiotomy? Y / N  
Natural children (your age/other parent): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Stillbirths / abortions (your age/other parent): \_\_\_\_\_  
\_\_\_\_\_

Hysterectomy: Y / N Date \_\_\_\_\_ Oophorectomy: Y / N Date \_\_\_\_\_  
Treated for infertility? Y / N Date \_\_\_\_\_

Current contraceptive method: \_\_\_\_\_

Have you EVER used:  birth control pills? Age at onset \_\_\_\_\_ Total years used \_\_\_\_\_  
 birth control patch? Age at onset \_\_\_\_\_ Total years used \_\_\_\_\_  
 birth control pill ring? Age at onset \_\_\_\_\_ Total years used \_\_\_\_\_

Do you have regular pap smears? Y / N Do you have regular breast exams? Y / N  
If you are menopausal, age of menopause: \_\_\_\_\_ Are you on hormone therapy? Y / N  
Type: \_\_\_\_\_ For how long? \_\_\_\_\_  
Type: \_\_\_\_\_ For how long? \_\_\_\_\_  
Type: \_\_\_\_\_ For how long? \_\_\_\_\_

# SEXUAL HISTORY – PART I

Name: \_\_\_\_\_

Date: \_\_\_\_\_

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 all that may 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SEXUAL HISTORY – PART II**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Religion (Child) \_\_\_\_\_ (Present) \_\_\_\_\_

Presenting complaint: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Substance Use: \_\_\_\_\_

Abuse: \_\_\_\_\_

Earliest childhood memory: \_\_\_\_\_

Earliest sexual memory: \_\_\_\_\_

Whose idea was it: \_\_\_\_\_ Why did you agree: \_\_\_\_\_

Masturbation: Age \_\_\_\_\_ Were you ever sexually seduced, molested, or raped as a child? Yes No

\_\_\_\_\_

Age when sexually active: \_\_\_\_\_ Age of partner: \_\_\_\_\_

\_\_\_\_\_

Sex Education: Where \_\_\_\_\_ By whom \_\_\_\_\_

Favorite sexual fantasy: Sex of partner M F Age of partner: \_\_\_\_\_

Act(s) \_\_\_\_\_

Long term relationships including patient's and partner's ages:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

Reason for commitment:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

Reason for divorce or separation:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

On a scale of 0 - 10 (terrible = 0, 10 = perfect) rate each relationship:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

What would have improved it:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

What stimulates you: \_\_\_\_\_

Erotic responses: \_\_\_\_\_ Orgasmic: \_\_\_\_\_

How do you stimulate your partner: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Use of force: \_\_\_\_\_

How do you feel about your sexual orientation: \_\_\_\_\_

History of Sexual Pattern

Gender/Age Preference: _____	_____ Exhibitionism	_____ Sexual masochism
	_____ Fetishism	_____ Sexual sadism
Times/Week: _____	_____ Frotterurism	_____ Transvestic Fetish
	_____ Pedophilia	_____ Voyeurism
Who initiates: _____	_____ Paraphilia NOS	_____ Other _____

What acts: \_\_\_\_\_

Nocturnal seminal emissions/frequency: \_\_\_\_\_

Definition of love: \_\_\_\_\_

Self-concept: what do you

consider your best quality: \_\_\_\_\_

consider your greatest weakness: \_\_\_\_\_

like best about present partner: \_\_\_\_\_

see as major problem that brought you to therapy: \_\_\_\_\_

think would be of greatest help to you: \_\_\_\_\_

Comments: \_\_\_\_\_

Diagnosis: \_\_\_\_\_