Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

Billing Questionnaire

Patient Name: _____

DOB: _____

Address: _____ City_____

State: _____ Zip_____

Phone #: Home_____ Mobile_____

Email address: _____

Primary Care Physician Name: _____

Phone: _____ Fax: _____

Address: _____

Significant Other/Partner Name:

Emergency Contact Name (if not the same as above):

Emergency Contact Phone #:

Employer Name:

Insurance Info: BRING IN CARD TO PHOTOCOPY

Guarantor's Name:

Guarantor's DOB:

Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

Male History Questionnaire

Name: _____ Age: ____ Gender: M F

Occupation: _____

Referred by: _____

Primary Care Provider: _____

Other Practitioners (massage, chiropractor, acupuncturist, physicians)

_____

_____

_____

_____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

Are you able to maintain an erection during intercourse? Y N

Have you had an injury to the penis? Y N (please comment if yes)

_____

Do you take any hormones? Y N

If so, please list them: _____

Do you have a curvature to your penis ? Y N

Do you use tobacco in any form? Y N

If yes, what form? Smoke cigarettes, pipe, gum, chew, other

Circle any of the below risk factors for erectile dysfunction below:

Vascular: DM, Heart Disease, HTN, Hyperlipidemia, Stoke, Sleep Apnea
Neurologic: Spinal Cord or Brain injuires, Parkinson's, Alzheimer's Disease, Multiple Sclerosis
Other Penile Issues: Peyronie's disease, Cavernous Fibrosis, Penile Fracture
Hormonal Issues: Thyroid, Adrenal (cortisol), Hypogonadism, Hyperprolactinemia, Chronic Livers or Kidney disease, AIDS
Drug Induced: Blood Pressure Medications, Depression Meds, Antipsychotics, Recreational Drugs, Opioid Pain Medications, Antiandrogens
Psychogenic: Performance-related anxiety, Trauma, Relationship Issues, Depression, Anxiety, Stress, Abuse
Lifestyle: Obesity, Tobacco Use, Sedentary Lifestyle, Sleep Disturbances

Other: Scleroderma,

What surgeries have you had: _____

_____

_____

Radial Prostatectomy? Y N

Pelvic Radiation? Y N

Can you have an erection in other instances (when your partner is not present?

Y N

Have you been able to have an erection in the past? Y N

Have you used any medication to help with achieving an erection? Y N

If yes, what medication? _____

Did it help the problem? _____

Have you ever felt guilty or bad about not being able to have an erection?

Y N

Do you have a fear of intimacy? Y N

Have you used any devices to assist with getting an erection? Y N

If yes, name the device (for example penile pump, surgical implantation)?

_____

Do you have any of the following? (circle all that apply)

Weight gain/loss	Trouble sleeping	
Low desire to have sex	Brain Fog	Low Energy
Trouble with orgasm	Hair Loss	Brittle nails
Pain with sex	Temperature Intolerances	Hot Flashes
	Bleeding Gums	

Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

	Almost Never or Never	A few times (much less than half the time)	Sometimes (about half the time	Most times (much more than half the time)	Almost always or always
How often were you able to get an erection during sexual activity?	1	2	3	4	5
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	1	2	3	4	5
When you attempted intercourse, how often were you able to penetrate (enter) your partner?	1	2	3	4	5
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	1	2	3	4	5
	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
During sexual intercourse, how difficult was it maintain your erection to completion of intercourse?	1	2	3	4	5

Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

Allergies/Sensitivities

_____ _____

_____ _____

_____ _____

Past Surgery, Hospitalizations and/or Accidents

Date	Surgeries/Medical Issue
_____	_____
_____	_____
_____	_____
_____	_____

Medications & Supplements

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

What is your goal with seeing the doctor today?

_____

_____

602 NE 3rd Ave, Suite E, Camas WA 98607 P: 360 258 1746 F: 603 373 8094 www.DrStebbing.com

Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

Past Medical History & Family History

	Self	Mother	Father	Siblings	Grand-parents	Children
Alcoholism						
Alzheimer						
Arthritis						
Asthma/Lung Issues						
Bleeding Disorder						
Cancer(s)						
Depression/ Anxiety						
Diabetes						
Drug Abuse						
Epilepsy						
Glaucoma/Eye problems						
Heart Disease: (attack,palpitations)						
High Cholesterol						
High Blood Pressure						
Intestinal Issues: IBS, stomach						
Kidney Disease						
Liver Disease: Hepatitis						
Migraines						
Thyroid Issues						
OTHER:						

602 NE 3rd Ave, Suite E, Camas WA 98607 P: 360 258 1746 F: 603 373 8094 www.DrStebbing.com

Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

Social

Do you drink Alcohol? Y N How much? _____

Have you ever smoked? Y N

If you did in the past, when did you quit? _____

Do you follow a special Diet? Y N What type? _____

Do you exercise regularly? Y N How much? _____

Do you have any other Hobbies? Y N What are they?

_____

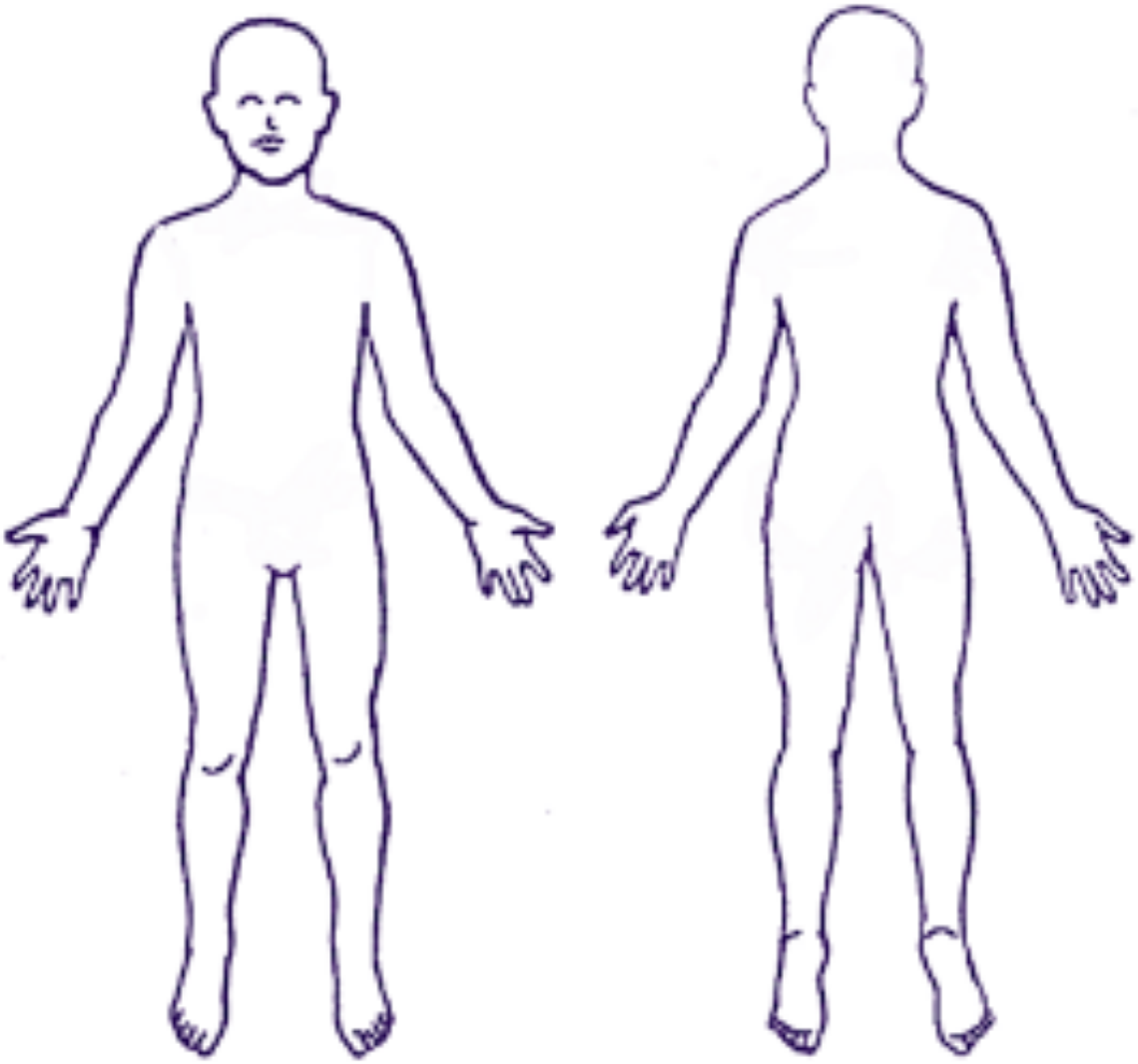
_____

How tall are you? _____ How much do you weigh? _____

SELECT THE WORD IN EACH ROW THAT BEST DESCRIBES YOU:

1. ____ **DETERMINED**	____ **CONVINCING**	____ **PREDICTABLE**	___ **CAUTIOUS**
2. ____ **STRONG WILLED**	____ PERSUASIVE	____ EASY-GOING	___ ORDERLY
3. ____ **DIRECT**	____ EXPRESSIVE	____ KIND	____ ANALYTICAL
4. ____ **BOLD**	____ SOCIABLE	____ COOPERATIVE	____ PRECISE
5. ____ **OUTSPOKEN**	____ ANIMATED	____ PATIENT	____ LOGICAL
6. ____ **DECISIVE**	____ TALKATIVE	____ LOYAL	____ CONTROLLED
7. ____ **DARING**	____ OUT-GOING	____ AGREEABLE	____ CAREFUL
8. ____ **RESTLESS**	____ ENTHUSIASTIC	____ CONSIDERATE	____ THOROUGH
9. ____ **COMPETITIVE**	____ INSPIRING	____ CONSISTENT	____ DETAILED
10. ____ **AGGRESSIVE**	____ PLAYFUL	____ SATISFIED	____ ACCURATE

Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE



PLEASE INDICATE WHERE YOU ARE EXPERIENCING:

PAIN with an X, DISCOMFORT with ////, and RADIATION of the pain or discomfort with #

602 NE 3rd Ave, Suite E, Camas WA 98607 P: 360 258 1746 F: 603 373 8094 www.DrStebbing.com