

Patient's name: _____

Date of birth: ____ / ____ / ____

MRN# _____

Medical history

1. Allergies

Medication	Reaction

Food	Reaction

Environment	Reaction

2. Prior surgeries/year

Year:	Illness:
Year:	Illness:
Year:	Illness:
Year:	Illness:

3. Serious illnesses/injuries/year

Year:	Illness:
Year:	Illness:
Year:	Illness:

4. Have you ever seen a urologist in the past? Yes No

If yes, when, who, where and what for? _____

5. Current medications list

Medication	Dosage	Year started	Prescriber

6. Social history

What is your martial status?

Married Divorced Single Widowed Separated

Habits?

Do you smoke? Yes Never Previous _____ packs per day _____ # of years
 _____ year quit

Do you chew tobacco? Yes Never

Do you consume alcohol? Yes Never
 Previous _____ drinks per day _____ # of years

Occupation: (if retired, previous) _____

7. Radiation exposure

Diagnostic _____ Therapeutic _____

8. Family history

	Mother	Age	Father	Age	Siblings	Age(s)
Living well						
Deceased						
Heart attack						
Stroke						
Diabetes						
High blood pressure						
Cancer						

Have you or anyone in your family had:

- Kidney stones Prostate cancer Kidney cancer or bladder cancer

If you selected any of the above, what was the relationship, age at onset and treatment?

9. Review of symptoms (Do you have or have you had? Please check as many as apply):

General:

Height _____ ' _____ " Weight _____

- Weight loss _____ pounds in _____ month
 Weight gain _____ pounds in _____ month
 Weight stable
 Fatigue Appetite _____ Good _____ Poor
 Fever Chills

Eyes:

Vision: _____ good _____ poor _____ corrected

- Eye pain Double vision

Respiratory:

- Hay fever Asthma Chronic cough Emphysema
 TB Shortness of breath
 Pneumonia: If yes, when: _____

Cardiovascular:

- Chest pain Irregular pulse High blood pressure
 High cholesterol Valve disease Heart attack
 Varicose veins Heart murmur

Neurological:

- Seizures Stroke Dizzy spells
 Headaches Tremors Numbness
 Tingling

Gastrointestinal:

- Difficulty swallowing Indigestion
 Nausea Vomiting Abdominal pain
 Peptic ulcer Diarrhea Constipation
 Blood in stools Hemorrhoids

Ear/Nose/Throat:

- Sinus problems Hoarseness Decreased hearing
 Sore throat Ringing in ears

Musculoskeletal:

- Osteoporosis Muscle weakness
 Arthritis Back pain Gout

Psychiatric:

- Nervousness Depression Anxiety
 Mental illness Panic attacks

Hematology: Anemia Swollen glands Blood clotting problems
 Bruise easily

Skin: Rashes Hives Itching

Endocrine: Thyroid disease or diabetes

Cancer: What kind: _____ When: _____
Treatment of cancer: Surgery Radiation Chemo

OB/GYN: Method of contraception: _____
Age menses started: _____ Age ended: _____
First date of last period: _____ Pregnancies: _____
Deliveries: _____ Miscarriages: _____ Abortions: _____
Problems with pregnancies: _____



AUA symptom index for BP

	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
1. Over the past month or so, how often have you had a sensation of not emptying your bladder?	0	1	2	3	4	5
2. Over 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
3. Over 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
4. Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	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
7. Over the last 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
AUA symptom score = sum of questions 1-7 _____						

Please see reverse side.

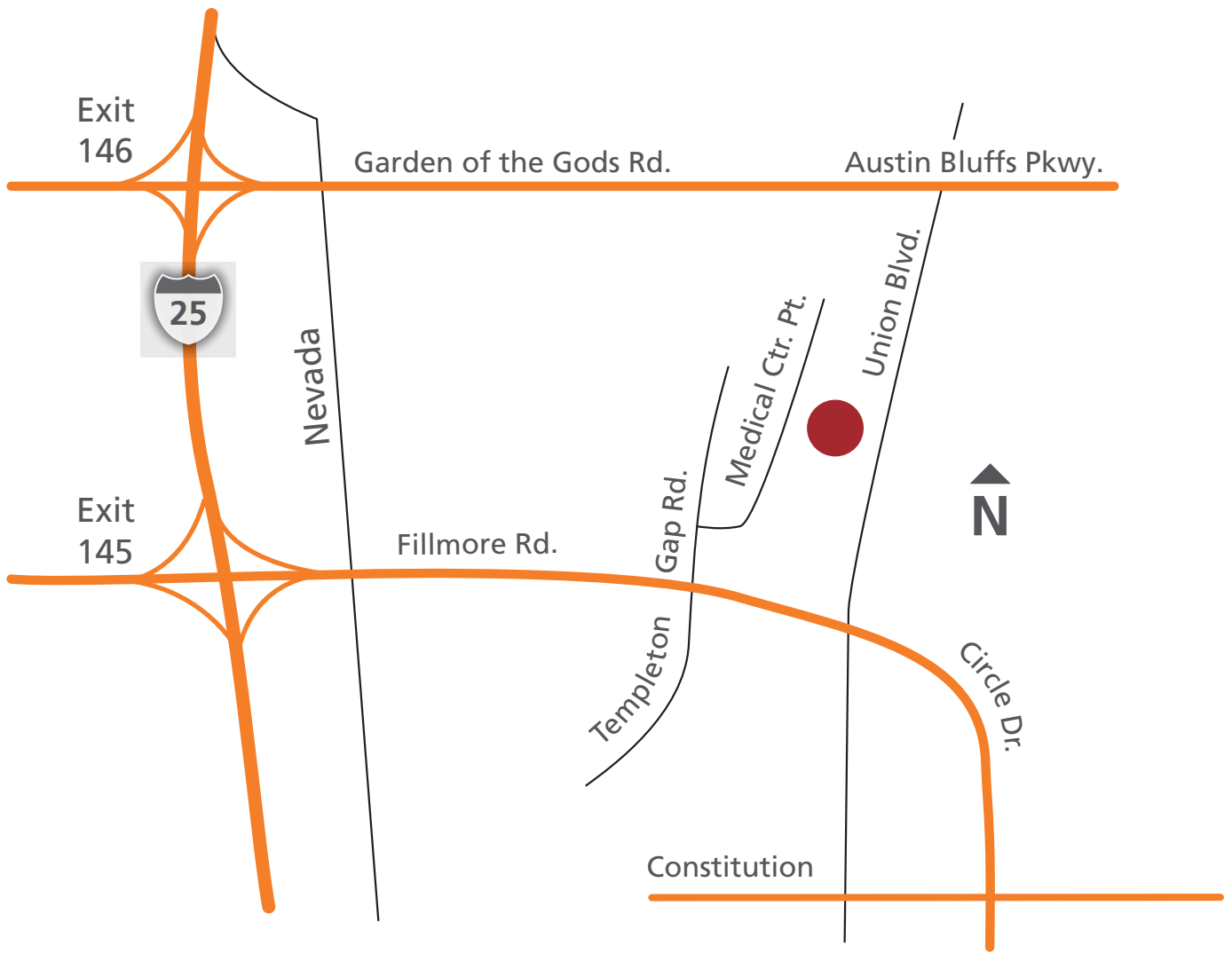


AUA symptom index for BP (continued)

				Not at all	A little	Some	A lot
1. Overall, how bothersome has any trouble with urination been during the last month?				0	1	2	3
	Delighted	Pleased	Mostly satisfied	Both satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
2. If you were to spend the rest of your life with those above symptoms just as they are now – how would you feel?	0	1	2	3	4	5	6

Patient's signature: _____

Date: ____ / ____ / ____



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