



Urology of Indiana

Name: _____ Date of Birth: ____ / ____ / ____ Today's Date: ____ / ____ / ____

Age: _____ Weight: _____ Height: _____ Race: _____ Sex: _____ Occupation: _____

Referring Dr. _____ Primary Dr. _____

What is the main reason for your visit today? _____

Check any past medical problems:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diverticular Disease | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> GERD | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Chronic UTIs | <input type="checkbox"/> Gout | <input type="checkbox"/> Lupus | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Neurologic Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Valvular Heart Disease |

Other: _____

Check any past surgical history:

- | | | | | | |
|---|------------|---|------------|--|------------|
| <input type="checkbox"/> Adrenalectomy | _____ date | <input type="checkbox"/> Liver Biopsy | _____ date | Gender Specific: Male | _____ date |
| <input type="checkbox"/> Appendectomy | _____ | <input type="checkbox"/> Kidney Removal | _____ | <input type="checkbox"/> Prostate Surgery | _____ |
| <input type="checkbox"/> Back Surgery | _____ | <input type="checkbox"/> Pacemaker | _____ | <input type="checkbox"/> Hydrocelectomy | _____ |
| <input type="checkbox"/> Bladder Augmentation | _____ | | | <input type="checkbox"/> Penile Prosthesis | _____ |
| <input type="checkbox"/> Heart Bypass | _____ | | | <input type="checkbox"/> Prostate Biopsy | _____ |
| <input type="checkbox"/> Colon Surgery | _____ | | | <input type="checkbox"/> Spermatocelectomy | _____ |
| <input type="checkbox"/> Heart Stent | _____ | | | <input type="checkbox"/> Testicle Removal | _____ |
| <input type="checkbox"/> Cystectomy | _____ | Gender Specific: Female | _____ date | <input type="checkbox"/> Varicocele Ligation | _____ |
| <input type="checkbox"/> Cystoscopy | _____ | <input type="checkbox"/> Bladder Suspension | _____ | <input type="checkbox"/> Vasectomy | _____ |
| <input type="checkbox"/> Gallbladder Removal | _____ | <input type="checkbox"/> Breast Biopsy | _____ | Other: | _____ |
| <input type="checkbox"/> Gastric Bypass | _____ | <input type="checkbox"/> Cesarean Section | _____ | _____ | _____ |
| <input type="checkbox"/> Hernia Repair | _____ | <input type="checkbox"/> Hysterectomy | _____ | _____ | _____ |
| <input type="checkbox"/> Hip Replacement | _____ | <input type="checkbox"/> Mastectomy | _____ | _____ | _____ |
| <input type="checkbox"/> Kidney Stone Removal | _____ | <input type="checkbox"/> Pubovaginal Sling | _____ | _____ | _____ |
| <input type="checkbox"/> Knee Replacement | _____ | <input type="checkbox"/> Tubal Ligation | _____ | _____ | _____ |
| <input type="checkbox"/> Laparoscopy | _____ | | | | |

Check any family history of illness:

- | | | | | | |
|--|--------------------|---|--------------------|---|--------------------|
| <input type="checkbox"/> Blood Disease | _____ Relationship | <input type="checkbox"/> High Blood Pressure | _____ Relationship | <input type="checkbox"/> Stroke | _____ Relationship |
| <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> Hyperlipidemia | _____ | <input type="checkbox"/> Thyroid Disorder | _____ |
| <input type="checkbox"/> Coronary Artery Disease | _____ | <input type="checkbox"/> Inflammatory Bowel Disease | _____ | <input type="checkbox"/> Urinary Tract Infections | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Kidney Stones | _____ | <input type="checkbox"/> Other: _____ | _____ |
| <input type="checkbox"/> Eczema | _____ | <input type="checkbox"/> Migraines | _____ | | |
| <input type="checkbox"/> Enlarged Prostate | _____ | <input type="checkbox"/> Renal Failure | _____ | | |
| <input type="checkbox"/> Gout | _____ | <input type="checkbox"/> Seizure Disorder | _____ | | |
| <input type="checkbox"/> Hearing Impairment | _____ | | | | |

MARITAL STATUS: S M D W Children? Y N How many children do you have? ____ Date of LMP _____

TOBACCO: Uses tobacco: Y N Former Tobacco Type: _____ Amount per day: _____

Number of years ____ Have you tried to stop? Y N Second hand smoke exposure? Y N

CAFFIENE: Y N Type: _____/_____ Amount of caffiene per day _____

ALCOHOL: Drinks alcohol: Y N Formerly Type:_____ Frequency:_____ Amount:_____ Last Drink:_____

IMMUNIZATIONS: Tetanus Y N date:_____ Influenza Y N date:_____ Pneumonia Y N date:_____

Review of Systems: Check if you are currently experiencing any of the following symptoms. Please mark Yes or No for each selection. Additional information may be added in the Notes section at the bottom of the page.

Constitutional:

Yes No

- Chills
- Fever
- Weight Loss
- Other:

Cardiovascular:

Yes No

- Chest Pain
- Heart Murmur
- Palpitations
- Varicose Veins
- Other:

Genitourinary:

Yes No

- Burning with Urination
- Erectile Dysfunction
- Blood in Urine
- Urinary Frequency
- Urinary Incontinence
- Inability to Urinate
- Other:

Metabolic/Endocrine:

Yes No

- Cold Intolerance
- Excessive Thirst
- Fatigue
- Male Breast Enlargement
- Heat Intolerance
- Hot Flashes
- Other:

Musculoskeletal:

Yes No

- Arthritis
- Back Pain
- Joint Pain
- Neck Pain
- Other:

HEENT:

Yes No

- Blurred Vision
- Double Vision
- Ear Infection
- Eye Pain
- Hearing Loss
- Sinus Infection
- Sore Throat
- Other:

Gastrointestinal:

Yes No

- Abdominal Pain
- Blood in Stool
- Constipation
- Diarrhea
- Heartburn
- Loss of Appetite
- Nausea
- Vomiting
- Other:

Reproductive - Male:

Yes No

- Penile Discharge
- Sexual Dysfunction
- Other:

Reproductive - Female:

Yes No

- Breast Lumps
- Breast Pain
- Vaginal Discharge
- Other:

Neurological:

Yes No

- Difficulty Walking
- Headache
- Memory Loss
- Seizures
- Tremors
- Other:

Hematologic/Lymphatic:

Yes No

- Easy Bleeding
- Lymphadenopathy
- Spontaneous Bruising
- Other:

Respiratory:

Yes No

- Chronic Cough
- Shortness of Breath
- Known TB Exposure
- Wheezing
- Other:

Integumentary:

Yes No

- Contact Allergy
- Hives
- Itching Skin
- Rash
- Other:

Psychiatric:

Yes No

- Anxiety
- Depression
- Insomnia
- Other:

Immunologic:

Yes No

- Asthma
- Food Allergies
- Other:

NOTES:

American Urological Symptom Score

1. Incomplete emptying:	Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?					
	Not at all <input type="checkbox"/> 0 pts	<1 time in 5 <input type="checkbox"/> 1 pt	< Half the time <input type="checkbox"/> 2 pts	Half the time <input type="checkbox"/> 3 pts	> Half the time <input type="checkbox"/> 4 pts	Almost always <input type="checkbox"/> 5 pts
2. Frequency:	Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?					
	Not at all <input type="checkbox"/> 0 pts	<1 time in 5 <input type="checkbox"/> 1 pt	< Half the time <input type="checkbox"/> 2 pts	Half the time <input type="checkbox"/> 3 pts	> Half the time <input type="checkbox"/> 4 pts	Almost always <input type="checkbox"/> 5 pts
3. Intermittency:	Over the past month, how often have you found that you stopped and started again several times when you urinated?					
	Not at all <input type="checkbox"/> 0 pts	<1 time in 5 <input type="checkbox"/> 1 pt	< Half the time <input type="checkbox"/> 2 pts	Half the time <input type="checkbox"/> 3 pts	> Half the time <input type="checkbox"/> 4 pts	Almost always <input type="checkbox"/> 5 pts
4. Urgency:	Over the past month, how often have you found it difficult to postpone urination?					
	Not at all <input type="checkbox"/> 0 pts	<1 time in 5 <input type="checkbox"/> 1 pt	< Half the time <input type="checkbox"/> 2 pts	Half the time <input type="checkbox"/> 3 pts	> Half the time <input type="checkbox"/> 4 pts	Almost always <input type="checkbox"/> 5 pts
5. Weak-stream:	Over the past month, how often have you had a weak stream?					
	Not at all <input type="checkbox"/> 0 pts	<1 time in 5 <input type="checkbox"/> 1 pt	< Half the time <input type="checkbox"/> 2 pts	Half the time <input type="checkbox"/> 3 pts	> Half the time <input type="checkbox"/> 4 pts	Almost always <input type="checkbox"/> 5 pts
6. Straining:	Over the past month, how often have you had to push or strain to begin urination?					
	Not at all <input type="checkbox"/> 0 pts	<1 time in 5 <input type="checkbox"/> 1 pt	< Half the time <input type="checkbox"/> 2 pts	Half the time <input type="checkbox"/> 3 pts	> Half the time <input type="checkbox"/> 4 pts	Almost always <input type="checkbox"/> 5 pts
7. Nocturia:	Over the past month or so, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?					
	None <input type="checkbox"/> 0 pts	1 time <input type="checkbox"/> 1 pt	2 times <input type="checkbox"/> 2 pts	3 times <input type="checkbox"/> 3 pts	4 times <input type="checkbox"/> 4 pts	5 or more times <input type="checkbox"/> 5 pts
Total Score _____ (please add all point values above)						
Quality of Life Due to Urinary Symptoms:						
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?						
<input type="checkbox"/> Delighted		<input type="checkbox"/> Pleased		<input type="checkbox"/> Mostly satisfied		
<input type="checkbox"/> Mostly dissatisfied		<input type="checkbox"/> Unhappy		<input type="checkbox"/> Terrible		
<input type="checkbox"/> Mixed						

Patient Signature _____ Date _____

Physician Signature _____ Date _____

Reviewed/updated (initials and dates) _____

