



Urology of Indiana

Today's Date: ____ / ____ / ____

Name: _____ Date of Birth: ____ / ____ / ____

Age: _____ Weight: _____ Height: _____ Gender: _____ Preferred Language: _____

Occupation: _____ Referring Dr.: _____

Primary Dr.: _____ What is the main reason for your visit today?: _____

Please circle:

- African American
- Alaskan Native
- American Indian
- Asian
- Black
- Hispanic
- Native Hawaiian
- Other Pacific Islander
- White
- Other: _____

Check any past medical problems:

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

Other: _____

Check any past surgical history:

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

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"/> High Cholesterol _____ | <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 When quit? _____ Tobacco Type: _____ Amount per day: _____

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

CAFFEINE: Y N Type: _____/_____ Amount of caffeine 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:

- No Yes
- Chills
 - Fever
 - Weight Loss
 - Other:

Cardiovascular:

- No Yes
- Chest Pain
 - Heart Murmur
 - Palpitations
 - Varicose Veins
 - Other:

Genitourinary:

- No Yes
- Burning with Urination
 - Erectile Dysfunction
 - Blood in Urine
 - Urinary Frequency
 - Urinary Incontinence
 - Inability to Urinate
 - Other:

Metabolic/Endocrine:

- No Yes
- Cold Intolerance
 - Excessive Thirst
 - Fatigue
 - Male Breast Enlargement
 - Heat Intolerance
 - Hot Flashes
 - Other:

Musculoskeletal:

- No Yes
- Arthritis
 - Back Pain
 - Joint Pain
 - Neck Pain
 - Other:

HEENT:

- No Yes
- Blurred Vision
 - Double Vision
 - Ear Infection
 - Eye Pain
 - Hearing Loss
 - Sinus Infection
 - Sore Throat
 - Other:

Gastrointestinal:

- No Yes
- Abdominal Pain
 - Blood in Stool
 - Constipation
 - Diarrhea
 - Heartburn
 - Loss of Appetite
 - Nausea
 - Vomiting
 - Other:

Reproductive - Male:

- No Yes
- Penile Discharge
 - Sexual Dysfunction
 - Other:

Reproductive - Female:

- No Yes
- Breast Lumps
 - Breast Pain
 - Vaginal Discharge
 - Other:

Neurological:

- No Yes
- Difficulty Walking
 - Headache
 - Memory Loss
 - Seizures
 - Tremors
 - Other:

Hematologic/Lymphatic:

- No Yes
- Easy Bleeding
 - Lymphadenopathy
 - Spontaneous Bruising
 - Other:

Respiratory:

- No Yes
- Chronic Cough
 - Shortness of Breath
 - Known TB Exposure
 - Wheezing
 - Other:

Integumentary:

- No Yes
- Contact Allergy
 - Hives
 - Itching Skin
 - Rash
 - Other:

Psychiatric:

- No Yes
- Anxiety
 - Depression
 - Insomnia
 - Other:

Immunologic:

- No Yes
- 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 do you awaken to urinate per night?						
	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) _____

