REASON FOR YOUR VISIT	

PRIOR EVALUATION BY UROLOGIST? (when, reason, and by whom)	

MEDICAL HISTORY (Please check all that apply and note how long the problem has existed)

☐ Abnormal heart rhythm / Atrial fibrillation	☐ Esophageal reflux	☐ Multiple sclerosis
☐ Anemia (Low blood count)	☐ Glaucoma	☐ Parkinson's Disease
☐ Arthritis	☐ Gout	☐ Sexually transmitted disease: _____
☐ Asthma / emphysema / COPD	☐ Heart attack / coronary artery disease	☐ Stroke / TIA
☐ Autoimmune or connective tissue	☐ Heart failure	☐ Thyroid disease
☐ Bleeding / clotting disorders	☐ High blood pressure	☐ Tuberculosis
☐ Blood clots in the legs or lungs	☐ High cholesterol	☐ Peptic ulcer disease
☐ Cancer: _____	☐ Hepatitis	☐ Urinary tract infections
☐ Colitis or inflammatory bowel disease	☐ HIV infection / AIDS	☐ Other: _____
☐ Depression or anxiety	☐ Infertility	☐ Other: _____
☐ Diabetes	☐ Kidney disease / Renal failure	☐ Other: _____
☐ Diverticulosis or Diverticulitis	☐ Kidney stones / Bladder stones	☐ Other: _____

SURGICAL HISTORY (Please check all that apply and circle the specific associated procedures, include dates)

☐ Appendectomy	☐ Gallbladder removal: open vs laparosc	☐ Prostate surgery: TURP
☐ Bladder tumor removal (Transurethral)	☐ Hernia repair: inguinal, umbilical	☐ Prostate removal: open / robotic
☐ Bladder removal (Total Cystectomy)	☐ Joint surgery: _____	☐ Vasectomy
☐ Coronary stent or bypass (CABG)	☐ Kidney stone surgery: _____	☐ Other: _____
☐ Colon surgery (Colectomy)	☐ Kidney surgery: total or partial removal	☐ Other: _____
☐ Eye surgery: _____	☐ Pacemaker placement	☐ Other: _____

FAMILY HISTORY Please note relation (parent, sibling, or offspring)

☐ Abnormal bleeding/bruising: _____	☐ Prostate cancer:_____	☐ Breast cancer: _____
☐ Genetic diseases: _____	☐ Kidney cancer: _____	☐ Problems with anesthesia: _____
☐ Kidney stones: _____	☐ Bladder cancer: _____	☐ Other: _____

SOCIAL HISTORY / HEALTH HABITS

Marital Status Single Mar Wid Div Sep	Whom do you live with?	Are you currently sexually active?

SMOKING STATUS	☐ Current	☐ Former:	☐ Never a Smoker
	☐ _____ packs/day	☐ How many years? _____	☐ Quit _____ yrs ago

ALCOHOL USE : ☐ No ☐ Yes: How many drinks / wk?	CAFFEINE USE : ☐ No ☐ Yes: How many drinks / day?

CURRENT OR FORMER OCCUPATION:

REVIEW OF SYSTEMS **Please check any symptoms that you have had in the last 6 months**

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Weight loss
- ☐ Poor appetite
- ☐ Fatigue

EENT

- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Hearing loss
- ☐ Recent vision changes

CARDIOVASCULAR

- ☐ Racing heart or palpitations
- ☐ Chest pain
- ☐ Calf pain with exercise
- ☐ Swelling of legs

Can you walk > 2 blocks or 2 stair flights without shortness of breath? ☐ **Yes** ☐ **No**

RESPIRATORY

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Changes in bowel habits
- ☐ Blood in the stools
- ☐ Heartburn

GENITOURINARY

- ☐ Blood in the urine
- ☐ Burning with urination
- ☐ Leakage of urine
- ☐ Flank / kidney pain
- ☐ Penile curvature

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle pain
- ☐ Decreased muscle mass
- ☐ Sciatica

SKIN

- ☐ Loss of hair
- ☐ Easy bruising

NEUROLOGICAL

- ☐ Tremor
- ☐ Dizziness
- ☐ Numbness in body part
- ☐ Headaches
- ☐ Incoordination
- ☐ Tingling / Pins and needles
- ☐ Paralysis

PSYCHOSOCIAL

- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Anxiety
- ☐ Difficulty sleeping
- ☐ Excessively high stress
- ☐ Memory problems
- ☐ Psychiatric care

LYMPHATIC / ENDOCRINE

- ☐ Lymph node tenderness
- ☐ Swollen glands
- ☐ Excessive thirst
- ☐ Intolerance to hot / cold
- ☐ Lack of energy or strength
- ☐ Decreased libido
- ☐ Increased body fat
- ☐ Hot flashes
- ☐ Loss of height (non-age related)

ANY KNOWN DRUG ALLERGIES? If so, please list drug and type of reaction it caused (rash, swelling, difficulty breathing, etc)

ANY ALLERGY TO LATEX (RUBBER PRODUCTS)? ☐ **No** ☐ **Yes - Describe:** _____

ANY ALLERGY TO SHELLFISH OR "IODINE DYE" (for X-ray studies)? ☐ **No** ☐ **Yes - Describe:** _____

CURRENT MEDICATIONS **Please include prescriptions, vitamins, supplements, and over-the-counter medication** ☐ **NONE**

AMERICAN UROLOGICAL ASSOCIATION SYMPTOM SCORE						
Please answer the following questions relating to the **LAST MONTH** or so	NOT AT ALL	LESS THAN 1 TIME IN 5	LESS THAN 1/2 THE TIME	ABOUT 1/2 THE TIME	MORE THAN 1/2 THE TIME	ALMOST ALWAYS
INCOMPLETE EMPTYING: How often have you had a sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
FREQUENCY: How often have you had to urinate again less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
INTERMITTENCY: How often have you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
URGENCY: How often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
WEAK STREAM: How often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
STRAINING: How often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**
NIGHTTIME: How many times did you typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	NONE **0**	1 TIME **1**	2 TIMES **2**	3 TIMES **3**	4 TIMES **4**	5 OR MORE **5**

QUALITY OF LIFE: How would you feel if you had to live with your urinary condition the way it is now for the rest of your life?	**DELIGHTED** **0**	**PLEASED** **1**	**MOSTLY SATISFIED** **2**	**MIXED** **3**	**MOSTLY DISSATISFIED** **4**	**UNHAPPY** **5**	**TERRIBLE** **6**

SEXUAL HEALTH INVENTORY FOR MEN

How do you rate **your confidence** that you could get and keep an erection?		VERY LOW **1**	LOW **2**	MODERATE **3**	HIGH **4**	VERY HIGH **5**
When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)?	NO SEXUAL ACTIVITY **0**	ALMOST NEVER OR NEVER **1**	A FEW TIMES **2**	ABOUT HALF THE TIME **3**	MOST TIMES **4**	ALMOST ALWAYS OR ALWAYS **5**
During sexual intercourse, **how often** were you able to maintain your erection after you had entered your partner?	DID NOT ATTEMPT INTERCOURSE **0**	ALMOST NEVER OR NEVER **1**	A FEW TIMES **2**	ABOUT HALF THE TIME **3**	MOST TIMES **4**	ALMOST ALWAYS OR ALWAYS **5**
During sexual intercourse, **how difficult** was it to maintain your erection to completion of intercourse?	DID NOT ATTEMPT INTERCOURSE **0**	EXTREMELY DIFFICULT **1**	VERY DIFFICULT **2**	DIFFICULT **3**	SLIGHTLY DIFFICULT **4**	NOT DIFFICULT **5**
When you attempted sexual intercourse, **how often** was it satisfactory for you?	DID NOT ATTEMPT INTERCOURSE **0**	ALMOST NEVER OR NEVER **1**	A FEW TIMES **2**	ABOUT HALF THE TIME **3**	MOST TIMES **4**	ALMOST ALWAYS OR ALWAYS **5**