ADC Urology- Questionnaire for Initial Patient Encounter

Patient Name	Referring Physician	Date of Visit

CHIEF COMPLAINT (Why are you seeing a urologist today?):

MEDICAL HISTORY (Please list current and past medical problems):

SURGICAL HISTORY (Please list surgical procedures you have had):

Procedure	Year

ALLERGIES (Please list allergies to medication):

Medication	Reaction

MEDICATIONS (Please list all medications you are currently taking and the dose):

Patient Name:

SOCIAL HISTORY:

Do you smoke?	**No_____ Yes____**
If Yes, # packs/day____ Years smoked____ If you have quit, then when?_____	
Daily caffeine intake (coffee, tea, soda)	
Do you use recreational drugs?	**No____ Yes____**
How many alcoholic drinks a week?	
Marital status	

REVIEW OF SYSTEMS:

Do you have problems with any of the following (circle if yes)	
General	**Recent weight changes, fever, weakness, fatigue, frequent headaches**
Integumentary	**Rashes, changes in skin/hair/nails**
Eyes	**Blurred vision, double vision, glaucoma**
Ears, Nose, Mouth, Throat	**Soreness/redness of gums, difficulty swallowing, earaches, sinus congestion**
Musculoskeletal	**Joint pain, neck pain, back pain**
Respiratory	**Wheezing, cough, difficulty breathing, asthma, bronchitis, pneumonia, tuberculosis, emphysema/COPD**
Neurologic	**Fainting, seizures, paralysis, tingling, tremors, memory loss, stroke**
Cardiovascular	**Chest pain, rapid heart beat, high blood pressure, swelling, faintness, dizziness, heart valve problems**
Endocrine	**Thyroid trouble, diabetes, fatigue, heat or cold intolerance, excessive sweating/thirst/hunger**
Gastrointestinal	**Change in appetite, nausea, vomiting, diarrhea, constipation, hemorrhoids, jaundice, heartburn, hepatitis**
Genitourinary	**Urinary: Frequent or painful urination, frequent UTI's, blood in urine, urinary retention** **Male: hernias, testicular problems, penile problems, erectile dysfunction, infertility** **Female: urinary incontinence, vaginal prolapse**
Hematologic/Lymphatic	**Anemia, easy bruising or bleeding, past transfusions, blood clots, difficulty clotting, swollen glands**
Psychologic	**Anxiety, depression, mood swings**
Allergy/Immunologic	**Food allergies, environmental allergies, HIV/AIDS**
Cancer	**If so, which type?**

Patient Name:

MALE AND FEMALE UROLOGIC QUESTIONNAIRE:

Circle the urologic issues you experience	**Males and Females: Frequent or painful urination, frequent UTI's, blood in urine, urinary retention, kidney stones, bladder tumor, kidney tumor, urinary leakage, post-void dribbling, urinary urgency, painful bladder syndrome/interstitial cystitis** **Males only: Testicular problems, penile problems, erectile dysfunction, infertility, prostate tumor, testicular tumor, enlarged prostate** **Females only: urinary incontinence, vaginal prolapse, mesh complications**
How often do you urinate?	**During the day? At Night?**
Duration of urinary leakage	**Duration (Months/Years):**
# of pads used a day	
Circle the activities that trigger urinary leakage	**Cough, laugh, lift, sneeze, exercise.** **Walking to the bathroom, putting keys in the door, washing hands, sitting, sleeping, standing up, intercourse/orgasm**
List past urologic surgeries or surgeries for urinary leakage	
List past/current medications taken for urinary leakage	
Circle the bowel issues you have	**Accidental leakage of stool, problems controlling gas, severe constipation**
How many glasses of fluids do you drink daily?	
Are you sexually active?	**Yes____ No____** **If not, is it due to (circle all that apply):** **Medical problems, absence of sexual partner, partner's medical problems, lack of desire**

FEMALES ONLY:

# of pregnancies:	**# vaginal deliveries:**	**# C-sections:**
Did you need any of these procedures during your delivery (circle all that apply)		**Forceps, extensive episiotomy, vacuum**
Weight of largest baby		
When was you last menstrual period?		

Patient Name:

FEMALES ONLY:

Are you on hormone replacement? If so, what type?	**Yes____ No____**
Have you had an abnormal PAP smear?	**Yes____ No____**

Have you had a hysterectomy? Yes____ No____

- **If yes, was it done abdominally or vaginally (circle)?**
- **Why was the hysterectomy done? Fibroids, heavy bleeding, cancer (circle).**
- **Did you have your tubes and ovaries removed as well?**

Do you have a bulge protruding from your vagina? Yes____ No____
If yes:

- **Symptoms associated with the bulge (circle all that apply):**
  - **Heaviness, pressure, difficulty urinating, incomplete bowel movements, need to push the bulge to urinate or have bowel movement, sensation of vaginal crowding, incontinence of stool**

MALES ONLY:

AMERICAN UROLOGICAL ASSOCIATION (AUA) SYMPTOM

Have you noticed any of the following when you have gone to the bathroom to urinate over the past month?
Circle the correct answer for you and write your score in the right-hand column

	Not at all	Les than 1 time in 5	Less than half the time	about half the time	More than half the time	Almost always	Your Score
Incomplete emptying - it does not feel like I empty my bladder all the way.	0	1	2	3	4	5	
Frequency- I have to go again less than two hours after I finish urinating.	0	1	2	3	4	5	
Intermittency - I stop and start again several times when I urinate.	0	1	2	3	4	5	
Urgency - It is hard to wait when I have to urinate.	0	1	2	3	4	5	
Weak Stream - I have a weak urinary stream.	0	1	2	3	4	5	
Straining - I have to push or strain to begin urination.	0	1	2	3	4	5	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 times or more**	**Your Score**
Nocturia - I get up to urinate after I go to bed until the time I get up in the morning.	0	1	2	3	4	5	
						Total AUA Symptom Score	

Total Score: 0-7 mild symptoms; 8-19 moderate symptoms; 20-35 severe symptoms

Quality of life due to urinary symptoms							
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	Delighted	Pleased	Mostly Satisfied	Mixed: about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible