ACADEMIC UROLOGY

# PATIENT QUESTIONNAIRE

**Name:** _____ **Date:** _____

**Date of Birth:** _____ **Age:** _____

**Marital Status:** Married Single Divorced Widow Separated Unknown

**What is the main reason that you are seeing the doctor today**?

_____

_____

**Your Past Medical History: Please check all that apply**

A) Medical Conditions

_____ Diabetes
_____ High Blood Pressure
_____ Heart Attack
_____ Stroke
_____ Pacemaker
_____ Bleeding Problems
_____ Cancer of _____
_____ Other _____
_____

B) Diseases of: (please explain)

_____ Heart (coronary artery disease, cardiomyopathy, etc. _____
_____ Lungs (asthma, emphysema, etc.) _____
_____ Liver _____
_____ Kidneys _____
_____ Nervous System (seizures, etc.) _____
_____ Immune System (AIDS, etc.) _____
_____ Other _____
_____

Do you require antibiotics for dental/medical procedures? Yes No
What drug? _____ Why? _____

**Surgeries**: Please note approximate date and hospital performed:

_____

_____

_____

**Family History**: List your parents' ages & medical conditions if living. If parents are deceased, list ages and cause of death.
Father: _____
Mother: _____
Children? Yes No Number _____

Have you ever had a blood transfusion? _____
Have you ever been diagnosed with MRSA?_____

**Cigarettes**: (packs per day) _____
Yes Not Anymore Never Smoked

**Alcoholic Beverages**: (drinks per day) _____
# Caffeinated beverages per day _____

**ALLERGIES**: (list all allergies to medications, anesthetics, contrast agents, etc…) _____
_____

Is there a family history of: Prostate Cancer Kidney Cancer Bladder Cancer Kidney Stones Diabetes

Heart Attack Stroke Cancer Bleeding Disorders

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# REVIEW OF SYSTEMS

PATIENT NAME: _____ DATE: _____

| Male Only | AUA Symptom Score: Circle one number in each line | | | | | |
|---|---|---|---|---|---|---|
| *Questions to be answered* | 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, how often have you had a sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. Over the past month, how often have you found you stopped and started again several times when you urinate? | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. Over the past month, how often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. Over the past month, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. Over the past month how often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. On a nightly basis, how many times do you typically get up to urinate? | 0 | 1 | 2 | 3 | 4 | 5 |

| **Quality of Life Due to Urinary Symptoms** | Delighted | Pleased | Mostly Satisfied | Mixed | Mostly Dissatisfied | Unhappy | Terrible |
|---|---|---|---|---|---|---|---|
| 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? | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| **Sum the seven circled numbers** (AUA Symptom Score): | **Scoring:** | Mild 0-7 | Moderate 8 - 19 | Severe 20-35 | | | |

Have you had a PSA? Y N

Result _____ Date: _____

Do you have trouble with?

Erections? Y N Do you want help with? Y N
Sex Drive? Y N Do you want help with? Y N

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**REVIEW OF SYSTEMS (continued)**

**Patient Name: _____ Date: _____**

**Do you have any problems now or have you had any related to the following systems?**
**PLEASE CIRCLE YES OR NO**

| **Constitutional Symptoms** | | |
|---|---|---|
| Fever | Yes | No |
| Chills | Yes | No |
| Weight Change | Yes | No |
| **HEIGHT:** | | |
| **WEIGHT:** | | |

| **Eyes** | | |
|---|---|---|
| Glaucoma | Yes | No |
| Cataracts | Yes | No |
| Blurry Vision | Yes | No |
| Double Vision | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Cardiovascular** | | |
|---|---|---|
| Chest pain | Yes | No |
| Heart Attack | Yes | No |
| Irregular Heartbeat | Yes | No |
| Swelling in Ankles | Yes | No |
| High Blood Pressure | Yes | No |
| Angina | Yes | No |
| Congestive Heart Failure | Yes | No |
| Problem with Heart Valves | Yes | No |
| Rheumatic Fever | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Psychological** | | |
|---|---|---|
| Anxiety | Yes | No |
| Depression | Yes | No |
| Difficulty Sleeping | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Genitourinary** | | |
|---|---|---|
| Change in Stream | Yes | No |
| Nocturia (getting up at night) | Yes | No |
| Urinary frequency >8 times/day | Yes | No |
| Dysuria (Burning with urination) | Yes | No |
| Blood in Urine | Yes | No |
| Urinary tract infection | Yes | No |
| Kidney Stones | Yes | No |
| Urinary Leakage | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Musculoskeletal** | | |
|---|---|---|
| Muscle weakness | Yes | No |
| Joint Pain(Swelling) | Yes | N0 |
| Arthritis | Yes | No |
| History of Orthopedic Surgery | Yes | No |
| Chronic Back Pain | Yes | No |
| Chronic Neck Pain | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Neurological** | | |
|---|---|---|
| Tremors | Yes | No |
| Dizzy Spells | Yes | No |
| Numbness/tingling | Yes | No |
| Stroke | Yes | No |
| Weakness | Yes | No |
| Difficulty walking | Yes | No |
| Loss of bowel control | Yes | No |
| Other | | |
| COMMENTS: | | |

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## REVIEW OF SYSTEMS (continued)

**Patient Name** _____ **Date**_____

| **Endocrine** | | |
|---|---|---|
| Excessive Thirst | Yes | No |
| Too Hot/Cold | Yes | No |
| Thyroid Condition | Yes | No |
| Diabetes | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Hematologic/Lymphatic** | | |
|---|---|---|
| Swollen Glands | Yes | No |
| Blood clotting problem | Yes | No |
| Easy Bleeding/Bruising | Yes | No |
| Anemia | Yes | No |
| Enlarged Lymph Nodes | Yes | No |
| Transfusion History | Yes | No |
| Immune Deficiency | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Respiratory** | | |
|---|---|---|
| Wheezing | Yes | No |
| Chronic Cough | Yes | No |
| Shortness of breath | Yes | No |
| Emphysema | Yes | No |
| Exposure to TB | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Gastrointestinal** | | |
|---|---|---|
| Abdominal pain | Yes | No |
| Nausea/vomiting | Yes | No |
| Indigestion/heartburn | Yes | No |
| Constipation | Yes | No |
| Diarrhea | Yes | No |
| Bloody or dark stools | Yes | No |
| Change in bowels | Yes | No |
| Other | | |
| COMMENTS: | | |

| **Sexual History** | | |
|---|---|---|
| Change in sex drive | Yes | No |
| Poor sexual performance | Yes | No |
| Other | | |
| COMMENTS: | | |