UROLOGICAL ASSOCIATES OF WESTERN COLORADO

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TEMP ___________
BP ___________
PULSE ___________
RR: ___________

DATE: ______________

NAME: ________________________________
DATE OF BIRTH: ________________________________
PRIMARY CARE PHYSICIAN: ________________________________

Please **circle** the correct answer to the following question:

1. Do you have difficulty starting your stream to urinate? Yes No Occasionally
2. Once you start your stream, can you go to the end? (most of the time) Yes No
   Or does your stream stop and stop while you are urinating? Yes No Occasionally
3. Do you have difficulty stopping your stream? Yes No Occasionally
4. Do you feel as if you empty your bladder (most of the time)? Yes No
5. Do you have to go to the bathroom frequently during the day? Yes No
6. Do you have to go again soon after you finsih urinating? Yes No Occasionally
7. How many times do you get up at night to go to the bathroom? 0 1 2 3 4 >5
8. Is the force of your stream strong or fair or weak ?
9. Do you dribble at the end of your urination? Yes No Occasionally
10. Do you have burning upon urination? Yes No Occasionally
11. Do you have pain upon urination? Yes No Occasionally
12. Do you leak urine before you can get to the bathroom? Yes No Occasionally
13. Do you leak urine with cough or sneeze? Yes No Occasionally
14. Do you have pain in your back, flank, abdomen, or pelvis? Yes No
15. Do you have blood in your urine? Yes No
    If yes-can you see it? Yes No

For Men Only:

16. Do you have blood in your ejaculate? Yes No
17. Do you have trouble with erections? Yes No
18. Do you have intercourse? Yes (Frequently Occasionally Rarely) No
19. Do your erections hurt? Yes No
20. Do your erections curve? Yes No

Past Medical History

Allergies: Sulfa Drugs Yes No | Penicillin Yes No
Iodine dye Yes No
Other Allergies ________________________________

Surgical History

Appendix Yes (Year__________) No
Heart Bypass Yes (Year__________) No
Heart Stents Yes (Year__________) No

Surgical History (continued)

Back Yes (Year__________) No
Gallbladder Yes (Year__________) No
Kidney Yes (Right or Left and Year__________) No
Bladder Yes (Year__________) No
Prostate Yes (Year__________) No
Hernia Yes No Side Right Left

For Woman Only:
Hysterectomy Yes (Year__________) No
Bladder Repair/Suspension Yes (Year__________) No

List Any Other Surgery: ____

Medical Illness:

Diabetes Yes No
High Blood Pressure Yes No
Heart Attack Yes No
Kidney Stones Yes No
Asthma Yes No
Hayfever Yes No
Jaundice Yes No
Cancer Yes No
Other Medical Illnesses: ____

Personal History: Married Single Spouse deceased
Children Yes (Number:____) No
Smoke Yes (Packs per day 1/2 1 2) No
Other tobacco products Yes No
Alcohol Yes No Occasionally

Family History: Mother Living Dead Age
Father Living Dead Age
Brothers Yes (#___) No Sisters Yes (#___) No
Did your father or brothers have prostate cancer? Yes No
Did your immediate family have: Diabetes Yes No
Kidney stones Yes No Heart disease Yes No
Cancer Yes No

Review of Symptoms: Do you have the following?
Head: Frequent headaches Yes No
Eyes: Diabetic Yes No Blindness Yes No
Do you wear glasses or contacts Yes No
Ears: Difficulty hearing Yes No Do you use a hearing aid Yes No
Nose: Frequent Nosebleeds Yes No
Chest: Chest Pain Yes No Occasionally :Shortnes of Breath Yes No
Heart: Heart murmur Yes No Heart palpations Yes No
GI: Good Appetite Yes No Unexplained weight loss Yes No
Bowel Movements Normal Constipation Loose/Diarrhea
Heartburn Yes No Blood on your stool Yes No
CNS: Loss of sensation in your arms or legs Yes No
Loss of ability to walk Yes No
Loss of ability to use arms or hands or legs Yes No