Advanced Urology Institute

Date: _____

PATIENT QUESTIONAIRE

Name: _____ Age _____ Date of Birth_____

Other Physicians involved in your care: _____

Date of Last Flu shot_____ **Date of Pneumonia Shot** _____

Medicines You are ALLERGIC to:	**Surgeries you have had:** **Year**	**Medications you take: Include Over-the-counter and supplements, vitamins**

FAMILY HISTORY: Has your Mother, Father, Brothers, Sisters or Children had any problems listed below: (please circle)

Hematuria	Y	N	**Heart Disease**	Y	N	**Easy Bleeding**	Y	N
Bladder Cancer	Y	N	**Kidney Disease**	Y	N	**Prostate Cancer**	Y	N
Kidney Stones	Y	N	**Hypertension**	Y	N	**Diabetes**	Y	N

SOCIAL HISTORY: **Marital Status**: (Circle) Married Single Divorced Widowed Separated

Do you Smoke? (Circle) Current Every Day Current Some Day Former Smoker Never Smoker Quit When? _____

Alcohol Use: (Circle) Yes Not Anymore Never **How Many Per Day** ____ **Caffeinated drinks per day:** _____

Race: (Circle) White Black Amer Indian/Alaska Asian Hawaiian Hispanic or Latino Unknown

Ethnicity (Circle) Hispanic/Latino Not Hispanic/Latino **Pref Language**: _____

IT IS IMPORTANT THAT THE DOCTOR IS AWARE OF ANY PROBLEMS YOU MAY HAVE OTHER THAN YOUR URINARY TRACT. PLEASE CIRCLE YES OR NO TO ANY OTHER PROBLEMS YOU MAY HAVE AT THIS TIME.

CONSTITUTIONAL			**Respiratory**			**Integumentary / Skin**		
Fever	Y	N	Shortness of Breath	Y	N	Rash	Y	N
Chills	Y	N	Wheezing	Y	N	Persistent Itching	Y	N
Weight Loss	Y	N	Chronic Cough	Y	N	Skin Cancer History	Y	N
EYES			**Gastrointestinal**			**Neurological**		
Blurry Vision	Y	N	Abdominal Pain	Y	N	Numbness	Y	N
Double Vision	Y	N	Nausea/Vomiting	Y	N	Tingling	Y	N
Cataracts	Y	N	Change in Bowels	Y	N	Dizziness	Y	N
EAR / NOSE / THROAT / MOUTH			**Genitourinary**			**Hematologic / Lymphatic**		
Hearing Loss	Y	N	Incontinence	Y	N	Swollen Glands	Y	N
Nasal Stuffiness	Y	N	Blood in Urine	Y	N	Abnormal Bleeding	Y	N
Sore Throat	Y	N	Sexual Dysfunction	Y	N	Easy Bruising	Y	N
Cardiovascular			**Musculoskeletal**			**Endocrine**		
Chest Pains	Y	N	Chronic Back Pain	Y	N	Low Libido	Y	N
Irregular Heartbeat	Y	N	Chronic Neck Pain	Y	N	Low Energy Level	Y	N
High Blood Pressure	Y	N	Arthritis	Y	N	Excess Thirst	Y	N

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To help the Doctor more efficiently serve you, please answer the following questions:

These questions are designed to assess your urinary symptoms over the last month or so. Please check your closest answer.

1. How often do you sense that you have not emptied your bladder completely after you finish urinating?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
2. How often have you had to urinate again less than 2 hours after you finished urinating?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
3. How often have you found it difficult to postpone urination?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
4. How often have you had a weak urinary stream?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
5. How often have you found you stopped and started again several times when you urinated?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
6. How often have you had to push or strain to begin urination?
   ☐ Not at all ☐ Rarely ☐ Less than half the time ☐ Half the time ☐ More than half the time ☐ Almost always
7. How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more times

Have you ever seen blood in your urine? ☐ Yes ☐ No

Does it burn or hurt when you urinate? ☐ Yes ☐ No

Have you had infections in the bladder? ☐ Yes ☐ No

Have you had infections in the kidneys? ☐ Yes ☐ No

Have you had infections in the prostate? ☐ Yes ☐ No

Have you ever had kidney stones? ☐ Yes ☐ No

Do you leak urine? ☐ Yes ☐ No

What causes you to leak? _____

Do you ever leak when you cough, sneeze or laugh? ☐ Yes ☐ No

What about when you exercise? ☐ Yes ☐ No

If you are a man, please answer these also:

When was the last time a doctor checked the prostate with a rectal finger exam? _____

When was your last PSA (Prostate Specific Antigen, the prostate cancer blood test)? _____

Can you recall the result? _____

Have you been told the prostate exam was abnormal? ☐ Yes ☐ No

Have you had a prostate biopsy? ☐ Yes ☐ No When? _____

Have you been told you prostate was enlarged? ☐ Yes ☐ No

Have you had the prostate "worked on"
(surgery, "roter rooter", TURP, dilations)? ☐ Yes ☐ No When? _____

Name: _____