REASON FOR VISIT

Any requests or additional information you would like to provideK

Symptoms in the LAST MONTH or since your last visit/procedure…

Typical number of times/day to empty bladder **during the waking hours**?	
FREQUENCY -- How often have you had to urinate again **less than two hours** after last urinating?	Select best description...
NOCTURIA -- Number of times per night you most typically wake up to urinate from the time you go to bed until the time you get up in the morning?	0
URGENCY -- How often have you found it **difficult to postpone** urination?	Select best description...
STRAINING -- How often have you had to **push or strain to begin urination**?	Select best description...
WEAK STREAM -- How often have you had a **weak urine stream**?	Select best description...
INTERMITTENCE -- How often have you **stopped and started** again several times when you urinated?	Select best description...
INCOMPLETE EMPTYING -- How often have you had a sensation of **not emptying completely** after you finished urinating?	Select best description...
HESITANCY -- How many times was there a **delay** in being able **to start** your urine stream?	Select best description...
SPLIT/SPLAYED URINE STREAM -- How often is your your urine stream split or splayed?	Select best description...
POSTVOID DRIBBLING -- How often have you had urine dribble out after you were done urinating?	Select best description...
URINARY QUALITY OF LIFE: If you were to spend the rest of your life with your URINARY CONDITION just the way it is now, you would feel... Select best description...	

__ **Abnormal urine color** _____
__ **Foul urine odor**
__ **Dysuria** --discomfort in urethra related to urination
__ **Urethral pain** --not associated with urination
__ **Suprapubic Pain** --above pubic bone in bladder area
__ **Flank Pain** between ribs and hip __ **RIGHT** __ **LEFT**
__ **Back Pain** Related to spine problems? __ **YES** __ **NO**
Location: Severity:

_____ _____

__ **Urinary Incontinence**–involuntary loss of urine with...
__ strong sudden urge __ intercourse
__ cough __ sneeze __ laugh __ strenuous activity
__ no sensation that bladder is full or need to empty

SEVERITY...
__ MILD—few drops
__ MODERATE—clothes damp
__ SEVERE—running down legs
__ INCAPACITATING—full bladder emptying

PROTECTIVE GARMENTS... __ NONE

__ LINERS	_____/day	_____/night
__ PADS	_____/day	_____/night
__ PULLUPS	_____/day	_____/night
__ DIAPERS	_____/day	_____/night
__ OTHER	_____/day	_____/night

__ **Fever**
__ **Weight Gain** _____ lbs in _____ _____
__ **Weight Loss** _____ lbs in _____ _____
__ **Chronic Constipation** Corrective measures?

_____

__ **Chronic Diarrhea** Corrective measures?

_____

__ Fecal Incontinence
__ Sexual Dysfunction
__ Painful intercourse

OTHER **SYMPTOMS** YOU ARE HAVING **TODAY**:

General: _____
Head/Eyes: _____
Ears/Nose/Throat: _____
Cardiovascular: _____
Respiratory: _____
Endocrine: _____
Psychiatric: _____
Neurologic: _____
Other: _____

___ **NO SYMPTOMS**

NAME: _____ DOB: _____ _____ DATE: _____