

Male Questionnaire-----ANSWER ALL QUESTIONS THAT YOU CAN on Pages 1-3, Fill in Name and Date on all pages

What is your reason for seeing the doctor?

(Please Circle)

Notes On Present Illness:

- [Yes] [No] Have you been seen previously in this office?
- [Yes] [No] Pain or burning with urination?
- [Yes] [No] Blood in urine at any time?
- [Yes] [No] Slow urinary stream?
- [Yes] [No] Difficulty starting urination?
- [Yes] [No] Incontinence or inability to hold urine (wet pants)?
- [Yes] [No] Urinating too frequently (more than 6 times a day)?
- [Yes] [No] Awakening at night to urinate more than once?
- [Yes] [No] Bedwetting?
- [Yes] [No] Urinary tract infection [Kidney] [Bladder] [Prostate]
- [Yes] [No] Kidney stone?
- [Yes] [No] Recent fevers or chills?
- [Yes] [No] Have you been to a urologist before?
- [Yes] [No] Have you had kidney or bladder x-rays before?
- [Yes] [No] Difficulty with erections?

-----Do not write in enclosed space-----

HPI

- Location
- Quality
- Severity + ++ +++ +++++
- Duration
- Timing
- Content
- Modifying factors
- Associated signs and sxs

AUA Score ___ ___ ___ ___ ___ ___ ___ **Total** _____ **QOL** _____

Name _____ Date _____

CONTINUE ON TO THE NEXT PAGE →

Do you take aspirin or any aspirin-containing drugs [Yes] [No]
Do you take over the counter medications [Yes] [No] If yes, list

List **all** previous operations or surgeries

List **all** previous serious illnesses or injuries

Has anyone in your family had prostate cancer [yes] [no] any hereditary disease [yes] [no]

Do you smoke cigarettes? [Yes] [No] If yes, how many packs per day? _____
If you have stopped, when did you stop? _____

Do you drink alcoholic beverages? [never] [occasional] [moderate] [heavy]

Occupation _____ [retired] Hobbies/FreeTime _____

Have you had problems with . . .? (circle if [Yes])

[Yes] [No] Eyes/Ears	[Yes] [No] Arthritis
[Yes] [No] Mouth/Throat	[Yes] [No] Joint problems
[Yes] [No] Heart attack	[Yes] [No] Back problems
[Yes] [No] Heart murmur	[Yes] [No] Anemia
[Yes] [No] Irregular heart rhythm	[Yes] [No] Bleeding tendency
[Yes] [No] Chest pain	[Yes] [No] Psychiatric problems
[Yes] [No] High blood pressure	[Yes] [No] Depression
[Yes] [No] Shortness of breath	[Yes] [No] Seizure/epilepsy
[Yes] [No] Cough	[Yes] [No] Stroke
[Yes] [No] Asthma	[Yes] [No] Headache
[Yes] [No] Stomach pain	[Yes] [No] Weight loss or gain
[Yes] [No] Ulcer	[Yes] [No] Chronic pain
[Yes] [No] Diarrhea	[Yes] [No] Sweats
[Yes] [No] Constipation	[Yes] [No] Diabetes
[Yes] [No] Blood in stool	[Yes] [No] Thyroid problems
[Yes] [No] Skin problems	

Have you had any blood tests for prostate cancer (PSA) [Yes] [No] (If yes, bring ALL prior values)

ARE THERE ANY OTHER PROBLEMS THAT HAVE NOT BEEN MENTIONED?

Name _____ Date _____

CONTINUE ON TO THE NEXT PAGE →

American Urological Association Symptom Score Sheet	Not at All	Less than 1 time in 5	Less than 1/2 the Time	1/2 the Time	More than 1/2 Time	Almost Always
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OVER THE PAST MONTH OR SO.....

Circle the appropriate number...

1. How often have you had a sensation of not emptying your bladder completely after you finished urinating? [0] [1] [2] [3] [4] [5]

2. How often have you had to urinate again less than 2 hours after you finished urinating? [0] [1] [2] [3] [4] [5]

3. How often have you found you stopped and started again several times when you urinated? [0] [1] [2] [3] [4] [5]

4. How often have you found it difficult to postpone urination? [0] [1] [2] [3] [4] [5]

5. How often have you had a weak urinary stream? [0] [1] [2] [3] [4] [5]

6. How often have you had to push or strain to begin urination? [0] [1] [2] [3] [4] [5]

7. How MANY times did you typically get up at night to urinate from the time you went to bed until getting up? Circle # of times..... [0] [1] [2] [3] [4] [5]

Bother Score = Sum of Questions 1 - 7 _____

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about it?

CIRCLE CHOICE ----->

- | | |
|--|---------------------------|
| [0] Delighted | [4] Mostly dissatisfied |
| [1] Pleased | [5] Unhappy |
| [2] Mostly Satisfied | [6] Terrible |
| [3] Mixed (about equally satisfied and dissatisfied) | |

NAME _____