Patient Name: ____ DOB: _________________________ Date: ____________________

Urologic Questionnaire

Select one answer per line	Not at all	Less than 1x in 5 days	Less than ½ the time	½ the time	More than ½ the time	Almost always	
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finish urinating	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
Over the past month or so, how often have you had to urinate again less than 2 hrs after you finished	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
Over the past month or so, how often have you found you stopped & started again several times when urinated	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
Over the past month or so, how often have you found it difficult to postpone urination	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
Over the past month or so, how often have you had weak urinary stream	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
Over the past month or so, how often have you had to push or strain to begin to urinate	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
	NONE	ONCE	2 TIMES	3 TIMES	4 TIMES	5 TIMES	MORE THAN 5 TIMES
Over the last month, how many times per night did you typically get up to urinate from the time you went to bed until you woke up in the morning	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6
	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now (no better, no worse) for the rest of your life	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6

Are you CURRENTLY experiencing any of the following?

❑ Blood in Urine	❑ Burning w/ urination	❑ Pain in kidneys	❑ Pain in bladder	❑ Pain in genitals
❑ Night sweats	❑ Unexplained weight loss	❑ Rash	❑ Excessive hairiness	❑ Eye pain
❑ Ringing in ears	❑ Double vision	❑ Memory loss	❑ Speech difficulties	❑ Hearing loss
❑ Joint pain	❑ Joint Swelling	❑ Palpitations	❑ Fainting	❑ Decreased libido
❑ Acne	❑ Sleep Apnea	❑ Coughing up blood	❑ Depression	❑ Anxiety
❑ Easy bruising	❑ Enlarged lymph nodes	❑ Pain w/ swallowing	❑ Bloody stool	❑ Other _______________

Please check any of the following medical issues that pertain to you (past and/or present):

❑ Abdominal Anuersym	❑ Fibromyalgia	❑ Lymphoma
❑ Anemia	❑ GERD/Heart Burn	❑ Malabsorption
❑ Anxiety Disorder	❑ Galucoma	❑ Multiple Sclerosis
❑ Asbestosis	❑ Gout	❑ Osteoarthritis
❑ Asthma	❑ Headaches	❑ Osteoporosis
❑ Atrial Fibrillation	❑ Hearing Impairment	❑ Parathyroid Disease
❑ Blood Clot Disorder	❑ Heart Attach/MI	❑ Parkinson's Diease
❑ Blood in Urine	❑ Heart Failure	❑ Peripheral Vascular Disease
❑ Bursitis	❑ Hemorrhoids	❑ Pheochromocytoma
❑ Cancer	❑ Hepatitis	❑ Pulmonary Embolus
❑ Carpel Tunnel Syndrome	❑ High Cholesterol	❑ Rheumatoid Arthritis
❑ Cataracts	❑ Hypertension	❑ Schizophrenia
❑ COPD	❑ Hypogonadism	❑ Seizures
❑ Cushing's Disease	❑ Incontinence	❑ Spina Bifida
❑ Degenerative Disc Disease	❑ Interstitial Cystitis	❑ Stroke
❑ Depression	❑ Irritable Bowel Disease	❑ Thyroid Disease
❑ Diabetes Type 1 or 2	❑ Jaundice	❑ TIA
❑ Dizziness	❑ Kidney Stones	❑ Tuberculosis
❑ Emphysema	❑ Leukemia	❑ Valvular Heart Disease
❑ Enlarged Prostate	❑ Low Platelets	❑ Vericose Veins
❑ Fibroid Uterus	❑ Lymes Disease	

Surgical History: Have you had any of the following surgeries or procedures?

❑ Angioplasty	❑ Appendectomy	❑ Back Surgery	❑ Bladder Surgery	❑ Cancer Surgery	❑ Cardiac Bypass
❑ Cardiac Pacemaker	❑ Cardiac Stent	❑ Cardiac Valve Surgery	❑ Colon/Bowel Surgery	❑ Gallbladder Surgery	❑ Hemorrhoid Surgery
❑ Hernia Repair	❑ Hysterectomy	❑ Incontinence Surgery	❑ Joint Replacement Surgery	❑ Kidney Stone Surgery	❑ Prostate Surgery for Cancer
❑ Testicle Removal	❑ Thyroid Surgery	❑ TURP	❑ Vasectomy		

Other: ____

Medication History: (Please list ALL current medications you are taking)

MEDICATION	DOSAGE	HOW TAKEN

Name of person filling out form (please print): ____

Relationship to patient: ______________________________

Signature: ____ **Date:** _________________________________