Reason for your visit: Routine Apptmt. Recent Surgery Procedure
Other: _____

Today I feel: **Well** **Ill** **Better** **Worse** **Other:** _____

Recent Symptoms (Please Circle):

General:
Chills
Fevers
Fatigue
Hot Flashes

Eyes
Cataracts
Glaucoma
Visual Changes

Neurologic:
Dizziness
Disorientation
Fainting
Headache

Abdominal:
Nausea / Vomiting
Abdominal Pain
Constipation
Diarrhea

Heart:
Chest Pain
Shortness of Breath
Swelling
Chest Palpitations

Skin:
Rash
Warts

Musculoskeletal:
Arthritis
Back Pain
Joint Pain

Respiratory:
Asthma
Cough
Wheezing
Difficulty Breathing

Please Circle the number for each question:

Over the last month I've:	**Never**	**1 in 5 Times**	**Less than ½ the time**	**Half the Time**	**More than ½ the Time**	**Almost Always**
Felt I didn't empty completely	0	1	2	3	4	5
Had to empty again less than 2 hours later	0	1	2	3	4	5
Stream stopped and Started	0	1	2	3	4	5
Unable to Postpone Voiding	0	1	2	3	4	5
Had a Weak Stream	0	1	2	3	4	5
Had to Push or Strain	0	1	2	3	4	5

# of Times Up at Night to Empty _____

How would you feel if you were to remain no better or worse than you currently are?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Unsatisfied	Terrible
	0	1	2	3	4	5

Incontinence: Do you leak urine? Yes No

If yes: When I cough / laugh Can't make it on time Both Don't know when I will

I use: _____ Pads / Diapers / day _____ Pads / Diapers / Night

In compliance with recent **US Government** regulations, all patients with: **Obesity, High Blood Pressure, Tobacco Use** are encouraged to see their **primary care physician** to manage these issues. People over the age of 50 should discuss getting an **influenza vaccine** with their primary care physician as well. Please note, primary management of these problems is not within the general scope of standard urologic practice. However, failure to address these issues with your primary care physician may have a detrimental impact on your urologic health. Should you have questions regarding the role these disorders may play in your urologic diagnosis, please do not hesitate to discuss this with your urologist.

Name:_____ ACCOUNT#_____

1. If you are over age 65, have you experience any urinary leakage?
   YES_____ NO_____
   *with an urge to void: YES_____ NO _____
   *with a cough or sneeze: YES_____ NO_____

2. If you are over age 65, have you undergone a DXA scan to screen for bone density strength (osteopenia or osteoporosis)
   YES_____ NO_____ if yes, approximate date: _____

3. If you are female between the ages of 40 and 69, have you had a mammogram?
   YES_____ NO_____ if yes, approximate date: _____

4. If you are between the ages of 51 and 75, have you had a colonoscopy?
   YES_____ NO_____ if yes, approximate date: _____

5. If you are 18 or older, did you receive an influenza vaccine during the flu season?
   YES_____ NO_____ if yes, approximate date: _____

6. If you are age 65 or older, have you received the Pneumococcal(Pneumonia) vaccine?
   YES_____ NO _____ if yes, approximate date: _____

7. If you are 18 or older, are you a current tobacco user or do you use smokeless tobacco?
   YES_____ NO _____