

Have you taken aspirin-containing products on a regular basis? No Yes

Have you taken steroid or cortisone-type drugs within the last year? No Yes

Please place a check (√) in the appropriate box for each organ listed. Describe the problem and type of surgery.

Past Medical History:

	Yes	No	If surgery performed please, check box.	Please provide details
Cardiovascular (Heart/circulatory, aneurysms)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary (Lungs, wheezing, cough, Shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal (Stomach/esophagus/ulcer/abdominal pain, nausea/vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Renal/Genitourinary(Kidneys/bladder) (change in stream, blood in urine, urinary leakage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological (tremors, dizziness, numbness/tingling, stroke, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine (diabetes/thyroid/parathyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hematologic (swollen glands, blood clotting, bruising)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal/Connective Tissue (muscle weakness, joint pain, sciatica, muscle pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy/Immunology/Dermatology (Skin rash, boils, persistent itch)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/ Hepatitis B/ Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other				

Have you ever been hospitalized? _____ If yes, which reason(s) and which date(s) _____

**Males Only:
AUA SYMPTOM INDEX**

Circle ONE number in each column that best answers the following questions:	Not at all	Less than 1 times in 5	Less than half the time	About half the time	More than half the time	Almost always
1. INCOMPLETE EMPTYING Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. FREQUENCY Over the past month or so, how often have you had to urinate again less an 2 hours after you finished urinating?	0	1	2	3	4	5
3. INTERMITTENCY Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. URGENCY Over the past month or so, how often have you found it difficult to postpone urinating?	0	1	2	3	4	5
5. WEAK STREAM Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. NOCTURIA On average, how many times do you most typically get up to urinate from the time you went to bed at night until the time you get up in the morning?	0	1	2	3	4	5
TOTAL						

GRAND TOTAL=

Quality of Life Bother Score

	Delighted	Pleased	Mostly Satisfied	Mixed (about equally satisfied and dissatisfied)	Mostly dissatisfied	Unhappy	Terrible
If you had to spend the rest of your life urinating just the way it is now, how would you feel about that?	0	1	2	3	4	5	6