

Review of Systems

Do you or have you had any problems related to the following symptoms? Circle Yes or No.
Please explain any Yes answers in space provided.

Name _____

Date _____

Constitutional:

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N

Musculoskeletal:

Chronic Back Pain	Y	N
Chronic Neck Pain	Y	N
Sore Muscles	Y	N

Eyes:

Blurred vision	Y	N
Double vision	Y	N
Cataracts	Y	N

Integumentary/Skin:

Rash	Y	N
Persistent Itching	Y	N
Skin Cancer History	Y	N

Ears/Nose/Mouth/Throat:

Hearing Loss	Y	N
Nasal Stuffiness	Y	N
Sore Throat	Y	N

Neurological:

Numbness	Y	N
Tingling	Y	N
Dizziness		

Cardiovascular:

Chest Pain	Y	N
Swollen Ankles	Y	N
Irregular Heartbeat	Y	N

Hematologic:

Swollen Glands	Y	N
Abnormal Bleeding	Y	N
Transfusion History	Y	N

Respiratory:

Shortness of Breath	Y	N
Wheezing	Y	N
Chronic Cough	Y	N

Genitourinary:

Incontinence	Y	N
Pain with Urination	Y	N
Blood in Urine	Y	N

Gastrointestinal:

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Change in Bowels	Y	N

Physician's Signature _____

Date _____

PATIENT ASSESSMENT and BLADDER SURVEY

Name: _____ Date: _____

Which symptoms best describe you? Check all that apply.

- Frequent Urination- Day, Night, and/or Both
- Sudden or Strong Urge to urinate
- Leakage with little or no warning-Sometimes unable to make it to the bathroom in time
- Unable to completely empty bladder- Feels like there is more even after voiding
- Accidental leakage with physical activity like exercising, sneezing or coughing
- Bladder or Pelvic Pain

Are you sexually active? Yes No

If you are sexually active do you now or have you ever had pain or symptoms during or after intercourse?

Please circle: Never Occasionally Usually Always

How long have you had any of the above symptoms? _____

Which symptom is the most bothersome to you? _____

Have you tried medications to help your bladder symptoms? Yes No

If yes, check the medications you have tried:

- Detrol LA Elavil Oxybutynin Toviaz
- Ditropan XL Elmiron Oxytrol Patch Vesicare
- Enablex Gelnique Sanctura XR Other _____

Have these medications helped your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10
<i>No Relief</i>					<i>Completely Cured</i>					

Are you still taking any of these medications? Yes No

If No, why have you stopped taking them?

- Did not work as well as expected Side Effects Expense
- Interaction with other taken medications Other

If Side Effects or Other, please explain: _____

Behavioral Modifications Tried? _____

(i.e.- reduced fluid intake; caffeine reduction; Kegel exercises; physical therapy; lifestyle changes)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10
<i>No Frustration</i>					<i>Complete Frustration</i>					

Are you interested in learning more about additional treatment alternatives to medications?

- Yes No

(OVER »)

Name: _____ Date: _____

Overactive Bladder Symptom Score (OABSS)

Question-Circle Score that best describes you	Response	Score
How many times do you typically urinate from waking in the morning until sleeping at night?	≤ 7	0
	8-14	1
	≥ 15	2
How many times do you typically wake up to urinate from sleeping at night until waking in the morning?	0	0
	1	1
	2	2
	≥ 3	3
How often do you have a sudden desire to urinate, which is difficult to defer?	None	0
	< once/week	1
	≥ one/week	2
	about once/day	3
	2-4 times/day	4
How often do you leak urine because you cannot defer the sudden desire to urinate?	≥ 5 times/day	5
	None	0
	< once/week	1
	≥ once/week	2
	about once/day	3
2-4 times/day	4	
≥ 5 times/day	5	

Quality of life due to urinary problems:

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 that? Circle the number that best reflects your feeling about your urinary problem.

0	1	2	3	4	5
<i>Pleased</i>					<i>Terrible</i>

PATIENT INFORMATION RECORD (FEMALES)

Name: _____

Reason (s) for visit: _____

Past and Current Health Problems: _____

Medication (s) and Supplements: _____

Allergies: _____

Surgeries/Hospitalizations: _____

Last Menstrual Period _____ Do you have regular periods? Y N

Have you been through menopause? Y N If so, have you had any bleeding after menopause? Y N

Have you experienced any abnormal bleeding between periods or heavy bleeding? Y N

If so, please explain: _____

How many pregnancies have you had? _____ How many miscarriages? _____

Please list births and specify mode of delivery (vaginal or caesarian section). Please include weights of birth.

Your occupation: _____ Marital Status _____

Do you smoke? Y N Have you ever smoked? Y N If so, when did you quit? _____

Do you drink alcohol? Y N If so, how many drinks per week? _____

Do you use any recreational drugs? Y N If so, what type? _____

What health conditions run in your family? Please list who has them _____

How many caffeinated drinks do you consume daily? _____

Language: English Spanish French Other _____

Race: White Black or African American American Indian Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Height: ___ft. ___in Weight: _____

Preferred Pharmacy and Pharmacy Address: _____

Signature _____ Date _____

**RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

I have received a copy of **Adult & Pediatric Urology and Urogynecology, P.C.'s**
Notice of Privacy Practices that became effective April 14, 2003.

Date

Printed Name

Signature

Note: If signed by someone other than the patient, we need written proof of your authority.

I, _____, give my permission to Adult & Pediatric Urology, P.C.,
to give any & all medical information regarding myself to the following person(s):

Signature

Date

For office use: A signature was not obtained because: _____

