

# 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

Name: \_\_\_\_\_

Reason(s) for visit \_\_\_\_\_

Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications and dose:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries/Hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical History (all health problems):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Family Medical History

	Heart Problems (please describe)	Cancer (please describe)	Other Major Problems
Mother			
Father			
Sister			
Brother			

**Smoking Status:** Current Smoker How much? \_\_\_\_\_  
Former Smoker When did you quit? \_\_\_\_\_  
Never Smoked

**Alcohol Status:** Do you drink alcohol? YES NO How much? \_\_\_\_\_

**Caffeine Status:** 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: \_\_\_\_\_ lb.

**Preferred Pharmacy and Pharmacy Address:** \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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**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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_