

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 _____

American Urological Association BPH Symptom Index Questionnaire

Name _____

Date _____

Having to urinate more frequently, as well as more urgently, can defiantly interrupt the flow of your day. You should know that frequent urination is often a symptom of benign prostatic hyperplasia (BPH), a noncancerous enlargement of the prostate gland. BPH is a common condition among men over the age of 50. Waking up several times a night to urinate and having a weaker, slower, or delayed urine stream are other common symptoms.

Circle the number that best applies to you

	Not at All	Less than 1 time in 5	Less than ½ the time	About ½ the time	More than ½ the time	Almost always
1. Incomplete Emptying Over the last month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
2. Frequency During the last month, how often have you had to urinate again less than two hours after you finish urinating?	0	1	2	3	4	5
3. Intermittency During the last month, how often have you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Urgency During the last month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Weak Stream During the last month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Straining During the last month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
7. Nocturia During the last month, how many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above, and write the total in the space to the right
 SYMPTOM SCORE = 1-7 MILD 8-19 MODERATE 20-35 SEVERE TOTAL _____

0=Delighted 1=Pleased 2=Mostly Satisfied 3=Mixed 4=Mostly Not Satisfied 5=Unhappy

8. Quality of life 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
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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 _____

**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: _____

