

NAME: _____

DATE: _____

DOB: _____

REVIEW OF SYSTEMS: Please circle if you have *recently* experienced any of the following:

Constitutional

Fever

Eyes

Blurred Vision

Allergic/Immunologic

Drug Allergies

Environmental Allergies

Neurological

Dizzy Spells

Headache

Numbness/Tingling

Tremors

Gastrointestinal

Nausea/vomiting

Cardiovascular

Chest Pain/Angina

High Blood Pressure

Genitourinary

Back Pain

Bedwetting

Blood in Urine

Dribbling

Burning on Urination

Erection Problems

Flank Pain

Hematuria

Hesitancy

Kidney Failure

Kidney Infections

Kidney Stones

Leak after voiding

Nocturia

Nocturnal Enuresis

Not Emptying

Painful Ejaculation

Stones

Suprapubic Pain

Urgency

Urinary Frequency

Urinary Hesitancy

Urinary Incontinence

Urinary Tract Infections

Urine retention

Urologic Cancer

Urologic Surgery

Vaginal Bleeding

Vaginal Discharge/Problems

Weak Stream

Respiratory

Shortness of breath

Wheezing

Patient Signature _____

Date _____

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BLADDER QUESTIONNAIRE

- | | YES | NO |
|--|-------|-------|
| 1. Do you leak urine when you cough, sneeze, laugh or exercise? | _____ | _____ |
| 2. If your answer to #1 was "yes", on average how much do you leak:
_____ "Drops" _____ "Tablespoons" _____ "Flood" | _____ | _____ |
| 3. If applicable has your leakage worsened over the last year? | _____ | _____ |
| 4. Do you ever leak urine without awareness that you are leaking? | _____ | _____ |
| 5. Are you wet upon awakening in the morning? | _____ | _____ |
| 6. Do you ever leak urine during sexual intercourse? | _____ | _____ |
| 7. When you have the "urge" to urinate, must you stop and go to the bathroom because it is such a strong urge? | _____ | _____ |
| 8. Do you ever leak urine when you have a strong urge to urinate?
(for example: you leak before you can get your underwear off) | _____ | _____ |
| 9. If your answer to #8 was "Yes", on average how much do you leak:
_____ "Drops" _____ "Tablespoons" _____ "Flood" | _____ | _____ |
| 10. On average, how many times during the day do you urinate? | _____ | _____ |
| 11. On average, how many times do you urinate after going to sleep? | _____ | _____ |
| 12. Do you have a problem with vaginal dryness? | _____ | _____ |
| 13. If you have gone through menopause, do you take hormone replacement medication? | _____ | _____ |
| 14. Do you feel that your urinary stream is restricted or slow? | _____ | _____ |
| 15. Do you have the sensation that after urinating you have fully emptied? | _____ | _____ |
| 16. Do you have to wear a pad or protective undergarment for leaking? | _____ | _____ |
| 17. If the answer to #16 was "Yes", how many times do you change daily? | _____ | _____ |

PATIENT NAME _____ AGE _____

ACCT.# _____

DATE _____