UROLOGY ASSOCIATES OF HOUSTON, P.A.

Please bring insurance cards, a picture I.D., any lab test, diagnostic test report, films, and completed paperwork to your appointment. **DO NOT MAIL** PAPERS TO OFFICE, BRING THEM WITH YOU TO THE APPOINTMENT.

Appointment date: _____
Appointment Time: _____

******Please arrive 30 minutes prior to your appointment******
Arrive by : _____

Your appointment is at our:

CLEAR LAKE
250 BLOSSOM #220
WEBSTER TX 77598
281-332-0202

MEMORIAL SOUTHEAST
11914 ASTORIA BLVD STE 520
HOUSTON TX 77089
281-481-2804

PEARLAND
10905 MEMORIAL HERMANN DR #211
PEARLAND TX 77584
281-332-0202 / 281-481-2804

To better treat you, please provide us with your pharmacy and physician name that you will want us to correspond with. Please return this page at your next visit.

PHARMACY Name:_____
Address:_____
Phone:_____
Fax:_____

PRIMARY CARE PHYSICIAN FULL NAME

Primary or Referring Doctor Name:_____
Address:_____
Phone:_____
Fax:_____

UROLOGY ASSOCIATES OF HOUSTON, P.A.

Receipt of notice of Privacy Practices
Written Acknowledgement Form

I, ______________________________ Date of Birth ____________ Account # ____________

I acknowledge that I have received a copy of UROLOGY ASSOCIATES OF HOUSTON, P.A.'s Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

______________________________ ______________________________ ____________________

SIGNATURE OF PATIENT / PARENT / GUARDIAN RELATIONSHIP TO PATIENT DATE

***You may notify us below regarding your request for confidential communications & restrictions*:**
(Please mark YES, NO, OR N/A)

1. **Please indicate where we may contact you by phone (at the numbers listed in your patient information).**

   Home: ___yes ___no __N/A **Work**: ___ yes ___no ___N/A **Cell Phone**: ___yes ___no ___N/A

2. **May we leave a message regarding your medical information on an answering machine or voice mail:**

   Home: ___yes ___no __N/A **Work**: ___ yes ___no ___N/A **Cell Phone**: ___yes ___no ___N/A

3. **May we leave a phone message regarding your medical information with any of the persons listed below:**

   Home: ___yes ___no __N/A **Work**: ___ yes ___no ___N/A **Cell Phone**: ___yes ___no ___N/A

List those persons to whom you permit Urology Associates of Houston, P.A., to discuss or release your medical information and their contact information..

______________________________ ______________________________

______________________________ ______________________________

* *

INFORMATION TO YOUR PHYSICIAN(S)

Urology Associates of Houston, P.A. will correspond with your referring physician and / or your primary care physician (PCP) regarding your diagnosis and treatment to coordinate your healthcare. Please list the name of your referring physician and / or primary care physician or write N/A: *If you have an HMO, you must list your PCP on file with your insurance company.*

DOCTOR:____

* *

AUTHORIZATION FOR THE TRANSMISSION OF MEDICAL RECORDS BY FAX OR ELECTRONIC SUBMISSION

I understand that Urology Associates of Houston, P.A., will be transmitting my medical records by fax in accordance with federal and Texas law, and I authorize you to do so. I also understand that Urology Associates of Houston, P.A. will be transmitting my medical records electronically and I authorize such transmission if the disclosure is made to another covered entity, as that term is defined in Urology Associates of Houston, P.A.'s Notice of Privacy Practices, for purposes of treatment, payment or health care operations or as otherwise authorized or required by Texas or federal law. I further understand that Urology Associates of Houston, P.A., must obtain my authorization for each electronic disclosure of my medical information that it makes for any other purpose. If another party inadvertently receives my medical records, I release Urology Associates of Houston, P.A., of any and all liability relating to such inadvertent submission of my records.

______________________________ ____________________

SIGNATURE OF PATIENT / PARENT / GUARDIAN DATE

Revised 10/12 (lh)

UROLOGY ASSOCIATES OF HOUSTON, P.A.

POLICY FOR INSURANCE PARTICIPANTS

If we are filing your insurance through a contracted plan, it is **YOUR RESPONSIBILITY** to notify the receptionist that you are on a certain plan and give your insurance card and/or referral to the receptionist ***BEFORE SERVICES ARE RENDERED***. Should you **NOT** have your insurance card and/or referral with you at the time of service, you will be asked to reschedule your appointment for a time when you can bring the insurance card and/or referral. **YOU MUST PRESENT A GOVERNMENT ID WITH YOUR PICTURE FOR US TO FILE YOUR INSURANCE.**

DEDUCTABLES AND CO-PAYMENTS WILL BE COLLECTED AT THE TIME OF THE VISIT, AND WE WILL BILL YOUR INSURANCE FOR THE BALANCE UNDER THESE PLAN PROVISIONS. WE HONOR ALL OUR INSURANCE CONTRACTS AND TAKE ADJUSTMENTS AS WE ARE INSTRUCTED BY OUR PAYORS. AFTER YOUR INSURANCE PAYS AND THE INSURANCE COMPANY SAYS THAT YOU STILL HAVE A BALANCE, YOU WILL BE RESPONSIBLE FOR THE BALANCE.

Some of the services rendered in this office are considered office surgery by your insurance company. This may result in a higher co-payment or charges may be subject to a surgical deductible and/or full payment of services rendered at the time of your visit.

If you understand and agree with this policy please sign below.

Thank You,

Dr.'s Barnes, Nguyen, Dow, Hoggatt and Vemana

_____ _____

Patient Signature Patient Printed Name

Account # _____

Date: _____

NAME: _____ ACCOUNT # _____

ADDRESS: _____
CITY STATE ZIP CODE

RACE: *(Circle one)* African-American, Asian, Caucasian-White, Hispanic, American Indian, Native Hawaiian, Pacific Islander, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Guamanian or Chamorro, Samoan, or OTHER.

PREFERRED LANGUAGE: _____

Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) If YES, Which? _____

TELEPHONE NUMBERS

HOME ☎ _____ WORK ☎ _____ CELL ☎ _____

APPPOINTMENT REMINDER CALLS ARE AUTOMATED. OUR COMPUTER IS PROGRAMED TO CALL YOUR HOME PHONE AFTER 5:00 PM THE NIGHT BEFORE YOUR APPOINTMENT.

CHECK THE PRIMARY PHONE NUMBER TO BE CALLED AFTER 5 PM: HOME ☐ WORK ☐ CELL ☐

◆ SOCIAL SECURITY # _____ ◆ TEXAS DRIVERS LICENSE # _____

◆ DATE OF BIRTH: _____ ◆ _____ ◆ SEX (CIRCLE): MALE FEMALE

◆ PLEASE CHECK: MARRIED ☐ SINGLE ☐ ◆ SPOUSE NAME / GUARDIAN _____

WIDOW ☐ DIVORCED ☐ SEPARATED ☐ SPOUSE / GUARDIAN PHONE ☎ _____

◆ PATIENT'S EMPLOYER _____

ADDRESS _____
CITY STATE ZIP

◆ NAME OF NEAREST FRIEND / RELATIVE *NOT LIVING* WITH YOU: NAME _____

PHONE _____

PRIMARY CARE PHYSICIAN OR

REFERRED BY DR. _____

◈ INSURANCE CO. NAME (PRIMARY) _____

CLAIMS ADDRESS _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT RELATIONSHIP TO THE POLICY HOLDER (*PLEASE CHECK*): SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

MEMBER ID # _____ GROUP # _____ EMPLOYER _____

◈ INSURANCE CO. NAME (SECONDARY) _____

CLAIMS ADDRESS _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT RELATIONSHIP TO THE POLICY HOLDER (*PLEASE CHECK*): SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

MEMBER ID # _____ GROUP # _____ EMPLOYER _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR FOR THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. I AUTHORIZE PAYMENT OF MEDICAL TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

Name: _____ **DOB:** _____ **ACCT.** _____ **Date:** _____

REFERRING DOCTOR: _____ FAMILY DOCTOR: _____

PHARMACY: _____ ADDRESS _____ CITY _____ TELEPHONE _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

PAST MEDICAL HISTORY PLEASE *CIRCLE* if you *have* or *have had* any of the following diseases or conditions *or* mark none of the above:

CARDIOVASCULAR
Anemia
Angina (Chest Pain)
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhythmia (Irregular Heartbeat)
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication (Pain in legs w/exercise)
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis (Blood clots)
Endocarditis (Heart Infection)
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia
☐ **NONE OF THE ABOVE**

ENDOCRINE/METABOLIC
Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyroidism (High)
Hypothyroidism (Low)
Impaired Glucose Tolerance (Borderline Diabetes)
☐ **NONE OF THE ABOVE**

GENERAL
ALLERGIES
ELECTRICAL Injury
Exposure to Chemicals
Hepatitis A
Hepatitis B

GENERAL (continued)
Hepatitis C
Hypercholesterolemia (High Cholesterol)
Hyperlipidemia
Infectious Disease
Lipid Disorder
Malaise (Weak/Tired)
Obesity
Paget's Disease
Polycystic Ovaries
Raynaud's Syndrome
Sleep Apnea
Hernia Location: _____
☐ **NONE OF THE ABOVE**

GI
Cholecystits (Gall Bladder Disease)
Cholelithiasis (Gallstones)
Chronic Liver Disease
Colitis
Constipation
Colon Condition (explain:
Crohn's Disease
Diarrhea
Diverticulitis
GERD (Acid Reflux, Indigestion)
Hemorrhoids
Hepatic Failure (Liver Failure)
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis
☐ **NONE OF THE ABOVE**

GU
Aids
Bladder Cancer
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency
Chronic Renal Failure
Crossed Fused Ectopia
Erectile Dysfunction
Hematuria
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones

GU (continued)
Libido Decreased (low sex drive)
Neurogenic Bladder
Orchitis (Testicular Infection)
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure
Recurrent UTI
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Ureteral Cancer
Undescended Testicle
Urinary Tract Infection
Venereal Disease (STD)
☐ **NONE OF THE ABOVE**

GYN/OB
Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids
☐ **NONE OF THE ABOVE**

HEENT
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Meniere's
Mumps
Sinusitis
Tinnitus (Ringing in ears)
Vertigo (Dizziness)
☐ **NONE OF THE ABOVE**

MUSCULOSKELETAL
Arthritis
Back Pain
Carpal Tunnel Syndrome
Claudication (Pain in legs with exercise)
Fibromyalgia
Morton's Neuroma
☐ **NONE OF THE ABOVE**

NEURO/PSYCH
ADHD

Name: _____ DOB: _____ ACCT. _____ Date: _____

NEURO/PSYCH (Continued)
Alcoholism
Alzheimer's Disease
Anxiety
Bi-Polar Disorder
Chronic Fatigue Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt
☐ NONE OF THE ABOVE

RESPIRATORY
Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis (TB)
☐ NONE OF THE ABOVE

TUMORS
Brain Cancer
Brain Tumor
Breast Cancer
Cervical Cancer

TUMORS (Continued)
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer (Stomach)
Laryngeal (Throat) Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Renal Cell Cancer (kidney)
Sarcoidosis
Testicular Cancer
Bladder Cancer
Ureter Cancer
Uterine Cancer
☐ NONE OF THE ABOVE

PLEASE LIST ANY OTHER DISEASES OR CONDITIONS:_____

_____

_____

SURGICAL HISTORY PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING SURGERIES AND INDICATE THE YEAR OF SURGERY:

CARDIOVASCULAR	YEAR
Angioplasty	
Aortic Aneurysm Repair	
CABG	
Carotid Artery Surgery	
Defibrillation	
Heart Surgery (Stents)	
Heart Transplant	
Pacemaker Insertion	
Vein Stripping	
GENERAL	
Brain Surgery	
Disc Surgery	
Lymphatic Node Dissection	
Parathyroidectomy	
Pilonidal Cyst Incision	
Skin Grafting	
GI	
Appendectomy	
Bariatric Surgery	
Bowel Resection	
Cholecystectomy	
Colon Resection	
Colonoscopy	
EGD	
EGD/Dilation Esophagus	
Fissurectomy	
Gall Bladder Surgery	
Hemorrhoidectomy	
Ileostomy	
Laparascopy	
Liver Surgery	
Liver Transplant	
Lumpectomy of Breast	

GI (Continued)	YEAR
Lysis Adhesions	
Nissen Fundoplication	
Splenectomy	
Stomach Surgery	
Umbilical Hernia	
Ventral Hernia Repair	
GU	
Bladder Surgery	
Biopsy Prostate	
Brachytherapy	
Circumcision	
Contigen	
Cystoscopy	
Cystoscopy – Dilation	
Cystoscopy – Retrograde	
Cystoscopy – Stent	
Cystoscopy – TUR Fulg	
Durashpere	
Epididymectomy	
ESWL (Shockwave Stones)	
Hernia Repair	
Hydrocelectomy	
Ileal Conduit	
Indigo Laser Surgery	
Inguinal (Groin) Hernia	
Interstim	
Kidney Stone	
Laser Treatment of Stone	
Meatotomy	
Needle Biopsy Prostate	
Nephrectomy (Removal of Kidney)	
Nephrolithotomy (Removal of stones)	
Orchiectomy	
Orchiopexy	

GU (Continued)	YEAR
Penile Implant/Prosthesis	
Penectomy	
Penile Surgery	
Pyeloplasty	
Radical Prostatectomy	
Renal Transplant	
Spermatocelectomy	
TUMT Prostate (Microwave)	
TUNA Prostate	
TURBT (Bladder Tumor)	
TUR Prostate	
Ureteroscopy	
Varicelectomy	
Vasectomy	
VLAP (Laser Ablation of Prostate)	
GYN	
Colposcopy	
Culdocentesis	
Hysterectomy	
Oopherectomy (Ovaries)	
Salpingectomy (Tubes)	
Tubal Litgation	
Vaginectomy	
Vulvectomy	
HEENT	
Cataract Surgery	
Corneal Surgery	
Ear Surgery	
Eye Surgery	
Facial Surgery	
Mastoid Surgery	
Nasal Surgery	

Name: _____ **DOB:** _____ **ACCT.** _____ **Date:** _____

HEENT (Continued)	YEAR
PEG (feeding tube)	
Septoplasty	
Sinus Surgery	
Tonsil Surgery	
Thyroid Surgery	
TMJ Surgery	

MUSCULOSKETAL	YEAR
Amputation	
Arthroscopic Knee Surgery	
Back Surgery	
Carpal Tunnel Surgery	

MUSCULOSKETAL (Continued)	YEAR
Cervical Spine Surgery	
Disc Surgery	
Foot Surgery	
Hand Surgery	
Hip Surgery	
Knee Surgery	
Leg Surgery	
Rotator Cuff Surgery	
Shoulder Surgery	

REPIRATORY	YEAR
Lung Surgery	

SKIN	YEAR
Basal Cell Carcinoma	
Melanoma	
Squamous Cell Carcinoma	

☐ **NO PRIOR SURGICAL HISTORY**

PLEASE INDICATE THE DATE(S) OF ANY OTHER SURGERIES AND DESCRIBE:_____

_____

_____

FAMILY HISTORY

PLEASE INDICATE WHICH FAMILY MEMBER HAS/HAD ANY OF THE FOLLOWING: (MOTHER, FATHER, BROTHER/SISTER, GRANDMOTHER, GRANDFATHER, AUNT AND UNCLE).

Arthritis	_____	Leukemia	_____
Bedwetting	_____	Liver Disease	_____
Bladder Cancer	_____	Malignant Melanoma	_____
Cancer (site unknown)	_____	Multiple Sclerosis	_____
Crohn's Disease	_____	Laryngeal (Throat) Cancer	_____
Depression	_____	Pancreatic Cancer	_____
Diabetes	_____	Prostate Cancer	_____
Gout	_____	Stroke	_____
Heart Attack	_____	Thyroid Disease	_____
Hypertension	_____	Tuberculosis	_____
Kidney Cancer	_____		
Kidney Disease	_____	OTHER	_____

☐ **UNREMARKABLE FAMILY HISTORY**

SOCIAL HISTORY

MARITAL STATUS:

_____ Single _____Married _____Separated _____Divorced _____Widowed _____Life Partner ____Common Law Spouse

Occupation:_____ **Number of Dependents (children):**_____

Alcohol Consumption: _____None _____Yes ____Occasional/Social # of drinks per day _____

Tobacco per day: _____None _____Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously smoked, when did you quit? _____

Caffeinated beverages: None Low(1-2) Moderate (3-4) Excessive (5 or more)

Name: _____ DOB: _____ ACCT. _____ Date: _____

ALLERGIES – DO YOU HAVE ANY ALLERGIES: YES ☐ NO ☐ PLEASE LIST ALL TYPES (Drug, seasonal, pets, environmental foods):

_____

_____

_____

CURRENT MEDICATIONS ☐ NONE ☐ LIST PROVIDED

Drug Name:	Dosage:	Directions/How you take it:

REVIEW OF SYSTEMS: Please circle if you have *recently* experienced any of the following *or* mark none of the above:

CONSTITUTIONAL
Fever
Fatigue
Generalized Weakness
Weight Gain
Weight Loss
☐ NONE OF THE ABOVE

EYES
Blurred Vision
Cataracts
Glasses
Glaucoma
Worsening Eyesight
☐ NONE OF THE ABOVE

ALLERGIC/IMMUNOLOGIC
Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies
☐ NONE OF THE ABOVE

NEUROLOGICAL
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors
☐ NONE OF THE ABOVE

ENDOCRINE
Diabetes
Excessive Thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold
☐ NONE OF THE ABOVE

GASTROINTESTINAL
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/Heartburn
Irregular Bowel Movements
Nausea/Vomiting
Rectal Bleeding
Tarry Stool
☐ NONE OF THE ABOVE

CARDIOVASCULAR
Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse

CARDOVASCULAR (Continued)
Orthopnea
Pain/Cramps Hips/Legs with exercise
Palpitation
Skipped Heart Beats
Swelling
☐ NONE OF THE ABOVE

SKIN
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin Rash
☐ NONE OF THE ABOVE

MUSCULOSKELETAL
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness
☐ NONE OF THE ABOVE

EAR / NOSE / THROAT
Ear Infection
Sinus Problem
Sore Throat
☐ NONE OF THE ABOVE

GENITOURINARY
Back Pain
Bedwetting
Blood in Urine

Name: _____ DOB: _____ ACCT. _____ Date: _____

REVIEW OF SYSTEMS: Please circle if you have *recently* experienced any of the following *or* mark none of the above:

GENITOURINARY (Continued)
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Stranguria
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy

GENITOURINARY (Continued)
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream
☐ NONE OF THE ABOVE

RESPIRATORY
Asthma
Emphysema-Bronchitis
Environmental Allergies
Pneumonia
Frequent Cough
Shortness of breath
Tuberculosis
Wheezing
☐ NONE OF THE ABOVE

HEMATOLOGICAL / LYMPHATIC
Swollen Glands
Blood Clotting Problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell
☐ NONE OF THE ABOVE

PSYCHOLOGIC
Anxiety
Depressed
Generally Satisfied with Life
☐ NONE OF THE ABOVE

UROLOGY ASSOCIATES OF HOUSTON, P.A.

Nathaniel L Barnes MD, F.A.C.S.
Diplomat American Board of Urology

Thanh A. Nguyen MD, F.A.C.S.
Diplomat American Board of Urology

Douglas S Dow MD, F.A.C.S
Diplomat American Board of Urology

Matthew D. Hoggatt MD
Diplomat American Board of Urology

Goutham Vemana MD

AUA SYMPTOM INDEX FOR BPH
COULD YOUR MALE URINARY SYMTPOMS BE CAUSED BY BPH?
Answer these simple questions and share them with your doctor.

		Not at all 0	Less than 1 time in 5 1	Less than Half the time 2	About half the time 3	More than Half the time 4	Almost always 5
1	**INCOMPLETE EMPTYING** Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?						
2	**FREQUENCY** During the last month, how often have you had to urinate again less than 2 hours after you finished urinating?						
3	**INTERMITTENCY** During the last month, how often have you stopped and started again several times when you urinated?						
4	**URGENCY** During the last month, how often have you found it difficult to postpone urination?						
5	**WEAK STREAM** During the last month, how often have you had a weak urinary stream?						
6	**STRAINING** During the last month, how often have you had to push or strain to begin urination?						
7	**NOCTURIA** During the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?						

Now add up you symptom Score (1-7 Mild, 8-19 Moderate, 20-35 Severe): _____

The Disease Specific Quality of Life Question

The Internatinal Prostate Symptom Score uses the same 7 questions as the AUA Symptom Index(presented above) with the addition of the following Disease Specific Quiality of Life Question (bother score) scored on a scale from 0 to 6 points (delighted to terrible).

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? _____

Delighted 0	Pleased 1	Mostly Satisfied 2	Mixed 3	Mostly Disappointed 4	Unhappy 5	Terrible 6

Adapted from American Urological Association. *Guideline on the Management of Benign Prostatic Hyperplasia (BPH).* Linthicum, MD: American Urological Association Education and Research, Inc.: 2003: 1-22, 1-23, 3-51.

ACCOUNT # _____

NAME: _____ AGE:_____ DATE:_____