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: _____

NAME: _____ ACCOUNT: _____

DATE OF BIRTH: _____ AGE:_____ DATE: _____

Referring Physician: _____ **Primary Care Physician:** _____

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
Flank Pain

GENITOURINARY (continued)
Kidney Failure
Kidney Infections
Kidney Stones
Leak after Voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Painful Ejaculation
Scrotal Pain
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

Other symptoms not listed:

_____

_____

_____

List any new diagnosis since your last visit.
IF NONE CHECK THIS BOX ☐

_____

_____

_____

If you have had any surgery since your last visit, list the surgery and the date below.
IF NONE CHECK THIS BOX ☐

_____

_____

_____

IF YOU HAVE NOT EXPERIENCED ANY OF THE ABOVE SYMPTOMS CHECK THIS BOX ☐

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Do you currently use tobacco? Yes or No

How many packs per day do you smoke? _____ Do you use smokeless tobacco? Yes or No

Have you previously used tobacco? Yes or No If yes, when did you quit? _____

How may packs per day did you smoke? _____

CURRENT MEDICATIONS: ☐ NONE ☐ LIST PROVIDED

DRUG NAME	*DOSAGE*	*DIRECTIONS/HOW YOU TAKE IT*
_____	_____	_____
_____	_____	_____
_____	_____	_____

USING A NEW PHARMACY? **IF SO, GIVE US YOUR NEW PHARMACY INFORMATION BELOW:**

NEW PHARMACY NAME _____ **ADDRESS** _____ **PHONE#**_____

PATIENT SIGNATURE: _____ **DATE:** _____