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 ☐

****

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: ______________

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 M.D.
Diplomat American Board of Urology

Goutham Vemana M.D.

BLADDER QUESTIONAIRE

		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?	_____	_____

ACCOUNT # ________________

NAME: ____ AGE:______ **DATE:**____________