UROLOGY INTAKE FORM

| **Are you experiencing any of these symptoms?** |
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| Do you wake up at night to urinate? If yes, how many times? | [Yes|No] [ \_\_\_ ] |
| Do you void frequently during the day? If yes, how many times? | [Yes|No] [ \_\_\_ ] |
| Do you have to rush to get to the bathroom? |  [Yes|No] |
| Do you have a slow/weak urine stream?  |  [Yes|No] |
| Do you have to wait for your pee to start? |  [Yes|No] |
| Do you have to push/bear down for your pee to start? |  [Yes|No] |
| Do you feel like you have some pee left in your bladder immediately after you pee? |  [Yes|No] |
| Have you seen blood in your urine? |  [Yes|No] |
| Have you ever had any pain in your pelvis/perineum? |  [Yes|No] |
| Do you have a history of urinary tract infections?If yes, how many times/how often? |  [Yes|No] [ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ]  |
| Do you have a history of kidney stones?If yes, how many times? |  [Yes|No] [ \_\_\_ ] |
| Have you ever been unable to pee ?If yes when? |  [Yes|No]  [ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ] |
| Have you ever had a catheter? |  [Yes|No] |

| **Do you take any medications?** (Specially those that you're taking for peeing better/prostate pills)?(Please list all medications to the best of your ability, name, dosage, how long been on this medication) |
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| Medications Taken: |
| Do you take any blood thinners? | [Yes|No] |
| Have you seen a urologist before? If yes, please explain why? | [Yes|No] [ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ] |
| Have you ever had your PSA measured? If yes, when was it? What was the number? | [Yes|No] |
| Have you ever had a prostate biopsy? If yes, when was it? What were the results? | [Yes|No] |
| Have you ever had a prostate MRI?If yes, when was it? | [Yes|No] |
| Have you ever had a transrectal ultrasound of the prostate? If yes, when was it? | [Yes|No] |
| Have you had a previous cystoscopy?If yes: Date of procedure: Location of procedure: Results:  | [Yes|No] |
| Do you smoke or use nicotine products on a daily basis: If yes:How many cigarettes per day? For how many years? | [Yes|No] |

| **Have you been diagnosed or suspected to have any of the following?** |
| --- |
| Kidney disease | [Yes|No|Unsure] |
| Sleep apnea If Yes, please indicate year of diagnosis | [Yes|No|Unsure]  |
| Bleeding tendency If Yes: please indicate year of diagnosis | [Yes|No|Unsure]  |
| Cancer If Yes: please indicate year of diagnosis and specify the type | [Yes|No|Unsure]  |
| Neurological diseases (MS, Parkinson's disease, feeling weakness or numbness in your hands or feet)  | [Yes|No|Unsure]  |
| Accidents or injury to the spine  | [Yes|No|Unsure]  |
| Degenerative disc disease | [Yes|No|Unsure]  |
| Diabetes Mellitus If Yes: please indicate year of diagnosis [on insulin|on pills|watching diet] | [Yes|No|Unsure]  |

| Do you have a family history of (prostate/bladder/kidney cancer)?If Yes: please indicate relation, type of cancer and age at the diagnosis |  [Yes|No]  |
| --- | --- |

| How much fluid do you drink during the day (how many glasses or cups)? (Including water, juice, coffee, tea, pop, energy drinks) |  [Yes|No]  |
| --- | --- |
| How much of it is after 6 PM? |  [Yes|No]  |