UROLOGY INTAKE FORM

| **Are you experiencing any of these symptoms?** | |
| --- | --- |
| 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) | |
| --- | --- |
| 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] |