NEW PATIENT

Please provide a brief history of your present urologic condition:

When first presented: _____

List any/all symptoms: _____

How often (occurrence) and length of duration: _____

List any aggravating factors: _____

List any relieving factors: _____

List additional treatment attempts: _____

Genitourinary:

Do you wake up at night due to the need to urinate? _____ How many times? _____

Do you urinate more than 8 times per day? _____

Do you experience a sudden urge to urinate? _____ Rare - Occasional - Frequent (circle one)

If yes, and you wait, will you experience pain? _____ Leakage? _____

Do you have leakage when you laugh / cough / sneeze ? _____

Do you have leakage immediately after urinating? _____

Is your urine stream strong? _____ Weak? _____ Intermittent? _____

Do you have trouble starting your stream, though the urge was present? _____

Do you have pain in your upper back? _____ Lower pelvis? _____ With intercourse? _____

Last gynecological exam? _____ List any abnormal findings: _____

Current female hormones or creams: _____

Indicate if <u>YOU</u> / <u>FAMILY</u> have a history of: (mark "**Y**" for you, "**F**" for family)

Blood in urine: _____ Kidney Stones: ____ / ____

More than two urinary tract infections in a single year: _____ Sexually transmitted disease: _____

# of pregnancies: _____ Deliveries: _____ Vaginal: _____ Caesarean Section: _____

Bladder Cancer: ____ / ____ Breast Cancer: ____ / ____ Kidney Stones: ____ / ____

Diabetes: ____ / ____ Multiple Sclerosis ____ / ____ Parkinson's ____ / ____ Alzheimer's: ____ / ____

Cataracts: _____ Glaucoma: _____ Blurred Vision: _____ Dry mouth: _____

Blood Clots: ____ / ____ Hypertension: ____ / ____ Asthma: ____ / ____ COPD: ____ / ____

Constipation: _____ Diarrhea: _____