New Patient/Annual MALE GENITOURINARY EXAM

Patient Name: _____ Age: _____ Date of Visit: _____

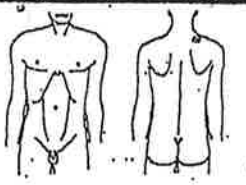
What is the main reason for your visit today? Describe your problem in detail _____

_____

_____

PLEASE ANSWER *EACH* OF THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE:

- **WHERE is your problem?**
  Abdomen / Back / Genitals / Other;
  Describe: _____



- **Do you have any PAIN?**
  YES NO (If "NO" skip the next question)
- **What KIND of pain do you have?** Sharp / Dull / Throbbing / Achy / Pressure / Cramping / Crushing / Vague
  Describe: _____
- **On a scale of 1-10, (10 is the most severe) circle the number that best describes the SEVERITY of your problem or your pain.**
  (no problem) 1 2 3 4 5 6 7 8 9 10 (most severe)
- **When did you FIRST NOTICE the problem? (When did it start?)**
  How many (circle one) days / weeks / month(s) ago: _____
- **HOW LONG does each episode last?**
  Seconds / Minutes / Hours / Days / Always there
  Describe: _____
- **WHEN does this problem happen?**
  Daytime / Nighttime / When you are active / Unpredictable
  Describe: _____
- **HOW OFTEN are you having the problem or the pain?**
  Describe: _____
- **What HELPS or what makes the problem WORSE?**
  Describe: _____
- **Are any OTHER SYMPTOMS occurring at the same time?**
  Describe: _____

- **List all of your current health conditions, and list all hospitalizations and surgeries you have had:**

_____ _____

_____ _____

_____ _____

_____ _____

- **List all medications you take regularly:**

_____ _____

_____ _____

_____ _____

- **List all medication allergies:**

_____ _____

_____ _____

- **Do you smoke?** No Yes How Much?
- **Do you use drugs or alcohol?** No Yes How Much?
- **What is/was your occupation?** (What did you retire from?)
- **What is your current marital status?**
  Single / Married / Seperated / Divorced / Widowed
- **List all serious illnesses in your family, including parents, grandparents and siblings.** (Diabetes, any kind of cancer, high blood pressure, heart disease, kidney disease or stones, thyroid disease, etc.)

Mother: _____
Maternal GM: _____
Maternal GF: _____
Father: _____
Paternal GM: _____
Paternal GF: _____
Bro./Sis.: _____

- **Do you have any of the following problems TODAY? Please mark YES (Y) or NO (N) for EACH item below.**

Y N **Kidney disease**	Y N Fever	Y N Wheezing	Y N Back pain	Y N Easy bruising
Y N **Bloody urine**	Y N Chills	Y N Frequent cough	Y N Headaches	Y N Seasonal allergies
Y N **Painful urination**	Y N Change in Weight	Y N Short of breath	Y N Tremors	Y N Other health problems
Y N **Urinary hesitancy**	Y N Change in appetite	Y N Abdominal pain	Y N Numbness or tingling	
Y N **Urinary retention**	Y N Blurred/double vision	Y N Nausea	Y N Dizzy Spells	
Y N **Urinary frequency**	Y N Eye pain	Y N Vomiting	Y N Anxiety	
Y N **Urinary urgency**	Y N Ear pain	Y N Indigestion	Y N Depression	
Y N **Urinary incontinence**	Y N Hearing loss	Y N Heartburn	Y N Insomnia	
Y N **Impotence**	Y N Sinus problems	Y N Skin problems	Y N Excessive thirst	
Y N **Dribbling/slow flow**	Y N Sore throat	Y N Skin cancer	Y N Intolerant to heat/cold	
Y N **Nighttime urinations**	Y N Chest pain	Y N Joint pain	Y N Tired or fatigued	
How many? _____	Y N Varicose veins	Y N Neck pain	Y N Swollen Glands	

Physician / provider use only (notes/comments)

Patient was offered CaP screening ☐ Yes ☐ No

Time in:

International Prostate Symptom Score (IPSS)

Patient Name: Date of Birth: Today's Date:

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – 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?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:		+	+	+	+	+

Total International Prostate Symptom Score = _____

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	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?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No