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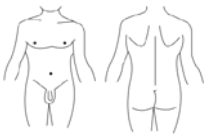
NEW PATIENT/ANNUAL MALE GENITOURINARY EXAM

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 occuring 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 your occupation? (What did you retire from?)

What is your current marital status?
Single/Married/Separated/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: _____
Brothers/Sisters: _____

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 Bloody Urine	Y N Chills	Y N Frequent Cough	Y N Headaches
Y N Painful Urination	Y N Change in Weight	Y N Short of Breath	Y N Tremors
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 Vision	Y N Double Vision	Y N Nausea
Y N Urinary Frequency	Y N Eye Pain	Y N Vomiting	Y N Anxiety
Y N Urinary Incontinence	Y N Hearing Loss	Y N Heartburn	Y N Excessive Thirst
Y N Urinary Urgency	Y N Sinus problems	Y N Skin problems	Y N Insomnia
Y N Impotence	Y N Sore Throat	Y N Skin Cancer	Y N Dizzy Spells
Y N Dribbling/slow flow	Y N Chest Pain	Y N Joint Pain	Y N Tired or Fatigued
Y N Nighttime Urinations	Y N Varicose Veins	Y N Neck Pain	Y N Swollen Glands
How Many? _____	Y N Intolerant to Heat/Cold	Y N Seasonal Allergies	Y N Easy Bruising

Physician/Provider use only (Notes/Comments)

Patient was offered CaP screening Yes ___ No ___

Time in:

International Prostate Symptom Score (IPSS)

TANNER CLINIC

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 fie	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 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.

Qualify 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