UROLOGIC HISTORY

PATIENT NAME: _____ DATE: _____

Please circle **Y** for yes and **N** for no for the following questions.

1. Have you ever had a bladder infection? **Y** **N** If yes, When? _____
2. Have you ever had a kidney infection? **Y** **N** If yes, When? _____
3. Have you ever had a prostate infection? **Y** **N** If yes, When? _____
4. Have you ever been told you have blood in your urine? **Y** **N** If yes, When? _____
5. Have YOU ever SEEN blood in YOUR urine? **Y** **N** If yes, When? _____
6. Have you ever had kidney stones? **Y** **N** If yes, When and Which side? _____
   Did you have surgery, or were you able to pass the stone? _____
7. Are you having pain or discomfort when you urinate? **Y** **N**
8. How many times during the daytime do you urinate? _____

Do you have problems with urine leakage? **Y** **N** How many pads do you wear a day? _____

Do you leak when you cough or sneeze? **Y** **N** Do you leak with strong urges that you cannot control? **Y** **N**

For questions 9 through 14 use this scale **Choose the number that best describes the frequency that you experience these conditions.**	**0** Not at all	**1** Less than 20% of the time	**2** Between 20%-50% of the time	**3** About 50% of the time	**4** Between 51%-90% of the time	**5** Over 90% of the time
9. Over the past month or so, how often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5
10. Over the past month or so, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
11. Over the past month or so, how often have you found that you stopped and started several times when you urinated?	0	1	2	3	4	5
12. Over the last month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
13. Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
14. Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

15. Over the past month or so, how many times per night did you get up to urinate?

_____None _____1 Time _____ 2 Times _____ 3 Times _____4 Times 5 times or more

Quality of life due to Urinary Symptoms	Delighted	Pleased	Mostly satisfied	Mixed- about equally satisfied and dissatisfied	Unhappy	Terrible
16. 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

Date	Sum

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