

LOUISVILLE UROLOGY - PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

**If this is the *FIRST TIME* you have been seen by this physician,
please mark all of the symptoms that apply to you.**

**If you have been seen by this physician *BEFORE TODAY*,
please mark all of the NEW problems you have experienced *since your last visit*.**

Please circle YES or No.

Constitutional Symptoms Fever Y N Chills Y N Weight loss Y N Weight gain Y N Neurological Tremors Y N Dizzy spells Y N Numbness/tingling Y N Other _____ Y N Endocrine Excessive thirst Y N Too hot/cold Y N Tired/sluggish Y N Other _____ Y N Gastrointestinal Abdominal pain Y N Nausea/vomiting Y N Indigestion/heartburn Y N Other _____ Y N	Cardiovascular Chest pain Y N Swelling feet or ankles Y N Palpitations Y N Other _____ Y N Musculoskeletal Joint pain Y N Neck pain Y N Back pain Y N Other _____ Y N Genitourinary Blood in urine Y N Painful urination Y N Urinary frequency Y N Other _____ Y N	Respiratory Wheezing Y N Frequent cough Y N Shortness of breath Y N Spitting up blood Y N Other _____ Y N Hematologic/Lymphatic Swollen glands Y N Blood clotting problem Y N Bleeding tendency Y N Other _____ Y N Psychologic Memory Loss Y N Nervousness Y N Depression Y N Other _____ Y N
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MALES ONLY - ALWAYS answer EVERY question in this section.

(Circle one number on each line)	Not at All	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Over the past month, how many times per night 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	1 time	2 times	3 times	4 times	5 or more times