Orange County Urology Associates –Patient Information Form (Male)

Name: _____ Today's Date: _____

Office Use Only	
Date	ROS by

Present Illness

How has your urologic condition changed since your last visit? ☐ Better ☐ Same ☐ Worse

_____

_____

_____

_____

Current Urinary Symptoms

☐ Frequency of urination
- Number of voids during the day? _____
- Number of voids during the night? _____

☐ Urgency
☐ Burning/ Painful urination
☐ Urethral discharge
☐ Incontinence (Involuntary Loss of Urine)
☐ Blood in urine
☐ Pain in Testicles
☐ Flank Pain
☐ Fevers/Chills
☐ Slow stream

Medications

Have there been any changes to your medications? ☐ No ☐ Yes, please note changes below

Name of Medication	*Dose*	*Times per Day*	*Name of Medication*	*Dose*	*Times per Day*

Have you had any new side effects to medicine? ☐ No ☐ Yes, list drug/effects

_____

Allergies ☐ ***NO KNOWN DRUG ALLERGIES***

List medications to which you are allergic. Please describe the reaction.

Drug Name: _____ **Allergic Reaction:** _____

Drug Name: _____ **Allergic Reaction:** _____

Do you have **sleep apnea**? ☐Yes ☐No Pacemaker? ☐Yes ☐No

Have you had any hospitalizations since your last visit? ☐ No ☐ Yes, please section complete below

When: _____ Reason: _____

Have you had any surgeries since your last visit? ☐ No ☐ Yes, please section complete below

Date: _____ Surgery: _____

Do you have any new medical problems since your last visit? ☐ No ☐ Yes, please list conditions below

_____ _____

_____ _____

_____ _____

Patient Name: _____ Date: _____

Prostate Symptom Score

Please answer the following questions:	**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**	
1. How often do you urinate again less than 2 hours after a prior urination?	0	1	2	3	4	5	**F Freq**
2. How often do you find it difficult to postpone urination?	0	1	2	3	4	5	**U Urge**
3. How often do you have a weak urination stream?	0	1	2	3	4	5	**↓ Stream**
4. How often do you push or strain to begin urination?	0	1	2	3	4	5	**S Strain**
5. How often do you find that you stop and start again when you urinate?	0	1	2	3	4	5	**I Interm**
6. How often do you have a sensation of not emptying your bladder after urination?	0	1	2	3	4	5	**PVR**
7. How many times do you typically get up to urinate when you go to bed at night?	None	1 time	2 times	3 times	4 times	5 or more	**N Next**
						TOTAL SCORE	_____/35

Quality of Life due to urinary symptoms	**Delighted**	**Pleased**	**Mostly satisfied**	**Mixed, equally satisfied and dissatisfied**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
8. How would you feel about spending the rest of your life with your urinary condition just the way it is now?	0	1	2	3	4	5	6