OREGON HEALTH & SCIENCE UNIVERSITY

Urology Initial Clinic Visit

Patient Name: _____
Date of Birth: _____
MRN: _____
Date of Service: _____

Referring Provider: _____

CHIEF COMPLAINT Please explain the reason for your visit:

_____

_____

PAST MEDICAL HISTORY Please list any medical conditions that you currently have:

1.	5.
2.	6.
3.	7.
4.	8.

SURGICAL HISTORY Please list any surgeries and their approximate dates:

Operation	Date	Operation	Date

PREFERRED PHARMACY

Name	Address/Phone Number

MEDICATIONS Please list all medications you are currently taking, including supplements:

Drug	Dose	Drug	Dose

ALLERGIES Please list any known allergies to medications, foods or other compounds:

☐ No known drug allergies ☐ Allergies: _____

FAMILY HISTORY Has anyone in your immediate family been diagnosed with the following:

☐ cancer type of cancer: _____ ☐ kidney or bladder trouble ☐ diabetes

☐ high blood pressure ☐ other family illness (including bleeding problems):_____

List the people living with you and their relationship to you: _____

What is your occupation?_____

If you are legally disabled, give the reason: _____

OREGON HEALTH & SCIENCE UNIVERSITY

Urology Initial Clinic Visit

Patient Name: _____
Date of Birth: _____
MRN: _____
Date of Service: _____

Referring Provider: _____

SOCIAL HISTORY Please check any of the following that apply to you:

TOBACCO USAGE:

☐ Never smoked

☐ Current smoker

How many packs a day do you smoke?

Approx. _____ packs a day.

For how long? _____months _____ years

☐ Previous smoker

If previous smoker, how long did you smoke before quitting? _____ months _____ years

Approximately _____ packs a day.

ALCOHOL USAGE:

☐ I do not drink

☐ I drink less than 2 drinks in a week.

☐ I drink approximately 2-5 drinks in a week.

☐ I drink approximately 6-10 drinks in a week.

☐ I drink more than 10 drinks in a week.

☐ Alcohol problem in the past

DRUG USE:

☐ Use of street-drugs

☐ Drug problem in the past

REVIEW OF SYSTEMS Are you currently experiencing any of the following symptoms?:

Constitutional		
YES	Fever	NO
YES	Chills	NO
YES	Weight Loss	NO
YES	Excessive fatigue	NO
YES	Sweating	NO
YES	Weakness	NO
Skin		
YES	Rash	NO
YES	Itching	NO
HENT		
YES	Headaches	NO
YES	Hearing loss	NO
YES	Ringing in ears	NO
YES	Ear pain	NO
YES	Ear discharge	NO
YES	Nosebleeds	NO
YES	Congestion	NO
YES	Stridor	NO
YES	Sore throat	NO

Endo/Heme/Aller		
YES	Easy bruise/bleed	NO
YES	Environmental allergies	NO
YES	Excessive thirst	NO

Eyes		
YES	Blurred vision	NO
YES	Double vision	NO
YES	Sensitive to light	NO
YES	Eye pain	NO
YES	Eye discharge	NO
YES	Eye redness	NO
Cardiovascular		
YES	Chest pain	NO
YES	Abnormal heart beat	NO
YES	Shortness of breath when lying flat	NO
YES	Leg pain when walking	NO
YES	Leg swelling	NO
YES	Sudden shortness of breath at night	NO
Respiratory		
YES	Cough	NO
YES	Coughing up blood	NO
YES	Sputum Production	NO
YES	Shortness of breath	NO
YES	Wheezing	NO

Neurological		
YES	Dizziness	NO
YES	Tingling	NO
YES	Tremor	NO
YES	Sensory change	NO
YES	Speech change	NO
YES	Focal weakness	NO
YES	Seizures	NO
YES	Loss of consciousness	NO

Gastrointestinal		
YES	Heartburn	NO
YES	Nausea	NO
YES	Vomiting	NO
YES	Abdominal pain	NO
YES	Diarrhea	NO
YES	Constipation	NO
YES	Blood in stool	NO
YES	Tar-like stools	NO
Genitourinary		
YES	Burning	NO
YES	Urgency	NO
YES	Frequency	NO
YES	Blood in urine	NO
YES	Flank pain	NO
Musculoskeletal		
YES	Muscle pain	NO
YES	Neck pain	NO
YES	Back pain	NO
YES	Joint pain	NO
YES	Falls	NO
Psychiatric		
YES	Depression	NO
YES	Suicidal	NO
YES	Substance abuse	NO
YES	Hallucinations	NO
YES	Nervous/Anxious	NO
YES	Insomnia	NO
YES	Memory loss	NO

OREGON HEALTH & SCIENCE UNIVERSITY

Urology Initial Clinic Visit

Patient Name: _____
Date of Birth: _____
MRN: _____
Date of Service: _____

Referring Provider: _____

Male Urinary and Sexual Health Questionnaire

(Check the box that is most applicable)

AUA SYMPTOM SCORE:	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. 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
2. Over the past month or so, how often have you had to urinate again less than two hours after you had finished urinating?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Over 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
4. Over the past month or so, how often have you found it difficult to postpone urination?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Over the past month or so, how often have you had a weak urinary stream?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Over the past month or so, how often have you had to push or strain to begin urination?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Over the past month or so, 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	1 time ☐ 1	2 times ☐ 2	3 times ☐ 3	4 times ☐ 4	5 times ☐ 5
8. If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about it?	Delighted ☐ 0	Pleased ☐ 1	Mostly Satisfied ☐ 2	Mixed ☐ 3	Unhappy ☐ 4	Terrible ☐ 5

SHIM – Sexual Health Inventory for Men (Male patients ONLY complete this section, Mark one box on each question)

1. How do you rate your confidence that you could get and keep an erection?

Very low	Low	Moderate	High	Very high
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner?)

Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered your partner?)

Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

4. During sexual intercourse, how difficult was it to maintain your erection until completion of intercourse?

Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

OREGON HEALTH & SCIENCE UNIVERSITY

Urology

Patient Name: _____
Date of Birth: _____
MRN: _____
Date of Service: _____
Physician: _____

Urinary Distress Inventory, Short Form (UDI-6)

For each question, circle the number that best describes this problem for you over the past month.

Do you experience and, if so, how much are you bothered by:

	Not at All	A Little Bit	Moderately	Greatly
Frequent Urination?	0	1	2	3
Urine leakage related to urgency?	0	1	2	3
Urine leakage related to physical activity? (walking, running, laughing, sneezing, coughing)	0	1	2	3
Small amounts of urine leakage? (drops)	0	1	2	3
Difficulty emptying your bladder or Difficulty urinating?	0	1	2	3
Pain or discomfort in your lower abdominal, pelvic, or genital area?	0	1	2	3

Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. Neurourol Urodyn 1995; 14: 131.

OREGON HEALTH & SCIENCE UNIVERSITY

Urology

Patient Name: _____
Date of Birth: _____
MRN: _____
Date of Service: _____
Physician: _____

Incontinence Impact Questionnaire, Short Form (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage over the past month.

Has urine leakage (incontinence) affected your:

	Not at All	Slightly	Moderately	Greatly
Ability to do household chores (cooking, housecleaning, laundry)?	0	1	2	3
Physical recreation such as walking, swimming, or other exercise?	0	1	2	3
Entertaining activities (movies, concerts, etc.)?	0	1	2	3
Ability to travel by car or bus more than 30 minutes from home?	0	1	2	3
Participation in social activities outside your home?	0	1	2	3
Emotional health (nervousness, depression, etc.)?	0	1	2	3
Feeling frustrated?	0	1	2	3

Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. Neurourol Urodyn 1995; 14: 131.

OREGON HEALTH & SCIENCE UNIVERSITY

Urology Initial Clinic Visit

Patient Name: _____
Date of Birth: _____
MRN: _____
Date of Service: _____

Referring Provider: _____

Physician Notes: