BaylorScott&White
UROLOGY ASSOCIATES
FORT WORTH
A member of HealthTexas Provider Network

Gonzalo Lievano, M.D., F.A.C.S.
1101 6th Ave, Suite 110
Fort Worth, TX 76104

Name: ______________________________ **DOB:** ______________________

	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	Your Score
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. Nocturia Over the past month, 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 this morning?	**None** 0	**1 time** 1	**2 times** 2	**3 times** 3	**4 times** 4	**5 times** 5	
TOTAL I-PSS SCORE →							
Quality of Life Due to Urinary Symptoms 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?	Delighted 0	Pleased 1	Mostly Satisfied 2	Mixed 3	Mostly Dissatisfied 4	Unhappy 5	Terrible 6

Patient's Signature: ______________________________ ***Date Completed:*** ____________________

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Patient Name: ______________________ **DOB:** ______________________
Referred By: ______________________ **PCP:** ______________________
Chief Complain: ____

DESCRIPTION OF PROBLEM/S	ALLERGIES
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

MEDICAL HISTORY

Condition	Yes	No	
Diabetes....................	Yes	No	______________________
High Blood Pressur..	Yes	No	______________________
Cancer.......................	Yes	No	______________________
Stroke........................	Yes	No	______________________
Heart Trouble...........	Yes	No	______________________
Arthritis / Gout........	Yes	No	______________________
Lung Problems.........	Yes	No	______________________
Bleeding Tendency..	Yes	No	______________________
Acute Infections.......	Yes	No	______________________
Venereal Disease.....	Yes	No	______________________
LMP...........................	Yes	No	______________________
Other.........................	Yes	No	______________________

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SOCIAL HISTORY

Married	______________________
Single	______________________
Widowed	______________________
Divorced	______________________
Separated	______________________
Occupation	______________________
Tobacco Use:	
Never	______________________
Proviously, but quit	______________________
Packs / Year	______________________
Alcohol Use:	
Never	______________________
Rarely	______________________
Moderate	______________________
Daily	______________________
Quit	______________________

PRIOR SURGERY OR TRAUMA HISTORY

Year	
__________	______________________
__________	______________________
__________	______________________
__________	______________________
__________	______________________
__________	______________________
__________	______________________
__________	______________________

MEDICATIONS

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____
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FAMILY HISTORY

Condition	Yes	No	
Diabetes....................	Yes	No	______________________
High Blood Pressure.	Yes	No	______________________
Cancer.......................	Yes	No	______________________
Stroke........................	Yes	No	______________________
Heart Trouble..........	Yes	No	______________________

HERBS

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Patient's Signature: ______________________ ***Date:*** ______________________

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	HAVE YOU OR ARE YOU BEING TREATED FOR: please check or circle all that apply		
	Diabetes		**GENITOURINARY**
	Hypertension		Frequent urination
	Cancer		Burning or painful urination
	Stroke		Blood in urine
	Heart Trouble		Change in force or strain when urination
	Arthritis/gout		Incontinence or dribbling
	CONSTITUTIONAL SYMPTOMS		Kidney stones
	Good general health		Ejaculation problems
	Recent weight change		Nocturia
	Fever		Male – Testicle pain
	Fatigue		Number of pregnancies
	Headaches		Number of miscarriages
	EYES		**MUSCULOSKELETAL**
	Eye disease or injury		Joint pain
	Wear glasses or contacts		Joint stiffness or swelling
	Blurred or double vision		Weakness of muscles or joints
	Glaucoma		Muscle pain or cramps
	EAR/NOSE/MOUTH/THROAT		Cold extremities
	Hearing loss or ringing		Difficulty in walking
	Earaches or drainage		**INTEGUMENTARY (skin/breast)**
	Chronic sinus problem or rhinitis		Rash or itching
	Nose bleeds		Change in skin color
	Mouth sores		Change in hair or nails
	Bleeding gums		Varicose veins
	Bad breath or bad taste		Breast pain / lump / discharge
	Sore throat or voice change		**NEUROLOGICAL**
	Swollen glands in neck		Frequent or recurring headaches
	CARDIOVASCULAR		Light headed or dizzy
	Heat trouble		Convulsions or seizures
	Chest pain or angina pectoris		Numbness or tingling sensations
	Palpitation		Tremors
	Shortness of breath with laying or lying flat		Paralysis
	Swelling of feet, ankles, or hands		Stroke
	RESPIRATORY		Head Injury
	Chronic or frequent coughs		**PSYCHIATRIC**
	Spitting up blood		Memory loss or confusion
	Shortness of breath		Nervousness
	Asthma or wheezing		Depression
	GASTROINTESTINAL		Insomnia
	Loss of appetite		Psychosis
	Change in bowel movements		**ENDOCRINE**
	Nausea or vomiting		Glandular problems
	Frequent diarrhea		Hormone problems
	Painful bowel movements or constipation		Excessive thirst
	Rectal bleeding or blood in stool		Tired / Sluggish
	Abdominal pain or heartburn		Diabetes
	Peptic ulcer		**HEMTALOGIC / LYMPHATIC**
	Convulsions		Slow to heal after cut
	Bleeding tendency		Anemia
	Acute infections		Phlebitis
	Venereal disease		Past blood transfusion
	Hereditary defects		Swollen glands

Patient's Signature: ____ ***Date:*** ____

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Gonzalo Lievano, M.D., F.A.C.S
Diplomate of the American Board of Urology
Minimally Invasive Robotic Surgery, General and Female Urology

Pharmacy Information

Pharmacy Name: ____

Street Address: ____

City: ____

Phone #: ____

Patient Name: ____