

Patient Name: _____

DOB: _____

Referred By: _____

PCP: _____

Chief Complaint: _____

DISCRIPTION OF PROBLEM/S	ALLERGIES

MEDICAL HISTORY	SOCIAL HISTORY
Diabetes..... Yes No _____ High Blood Pressure.... 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 _____ _____ _____	Married _____ Single _____ Widowed _____ Divorced _____ Separated _____ Occupation _____ Tobacco Use: Never _____ Previously, but quit _____ Packs / Year _____ Alcohol Use: Never _____ Rarely _____ Moderate _____ Daily _____ Quit _____

PRIOR SURGERY OR TRAUMA HISTORY	MEDICATIONS																				
<table border="1"> <thead> <tr> <th>Year</th> <th> </th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Year																				_____ _____ _____ _____ _____ _____ _____ _____ _____
Year																					

FAMILY HISTORY	HERBS
Diabetes..... Yes No _____ High Blood Pressure.... Yes No _____ Cancer..... Yes No _____ Stroke..... Yes No _____ Heart Trouble Yes No _____	_____ _____ _____ _____

Patient's Signature _____

Date _____

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	1 time	2 times	3 times	4 times	5 times or more	
0	1	2	3	4	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	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6

Patient's Signature _____

Date Completed _____

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 urinating
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
Heart trouble	Convulsions or seizures
Chest pain or angina pectoris	Numbness or tingling sensations
Palpitation	Tremors
Shortness of breath with walking 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	HEMATOLOGIC / LYMPHATIC
Convulsions	Slow to heal after cut
Bleeding tendency	Anemia
Acute infections	Phlebitis
Venereal disease	Past blood transfusion
Hereditary defects	Swollen glands

Signature _____ Date _____



Baylor Scott & White

SPECIALTY ASSOCIATES OF FORT WORTH

A Baylor Scott & White Health - HealthTexas Affiliate

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: _____