

FAMILY HISTORY: Please place a check in the appropriate box. If the answer is yes, list the family member affected.

Disease	Yes	No	Family member(s) affected
Hypertension			
Heart disease			
Cancer: list type and location			
Cysts or tumors of kidneys			
Sickle cell disease or trait			
Any family member on dialysis			

REVIEW OF SYMPTOMS:

Indicate whether or not you suffer from the following symptoms on a frequent or chronic basis by checking the appropriate box. If your answer is YES, please describe the symptoms in further detail.

Symptoms	Yes	No	Describe
1. Unexplained weight loss			
2. Fever, chills, night sweats			
3. Nausea			
4. Vomiting			
5. Blurred vision			
6. Double vision			
7. Runny nose			
8. Difficulty swallowing			
9. Chest pain			
10. Shortness of breath			
11. Diarrhea			
12. Abdominal pain			
13. Muscular weakness			
14. Numbness			
15. Joint pain			
16. Chronic itching			
17. Skin rashes			
18. Headaches			
19. Dizziness			
20. Fainting			
21. Anxiety			
22. Depression			
23. Tiredness			
24. Hyperactivity			
25. Extreme thirst			
26. Easy bruising			
27. Bleeding			

What is your height? _____ ft _____ in

What is your usual weight? _____ lbs

Your last complete physical examination? _____ By DR. _____

**MALES ONLY - PLEASE COMPLETE THE NEXT PAGE:
AUA SYMPTOM INDEX AND SEXUAL HEALTH INVENTORY**

AUA SYMPTOM INDEX

<div style="border: 1px solid black; border-radius: 50%; padding: 2px; display: inline-block;"> Circle ONE number in each column that best answers the following questions: </div>	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 2 hours after you 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 or more 5

SEXUAL HEALTH INVENTORY FOR MEN

Select the number that best describes your situation. Enter that number in the blank to the left of the question. Please be sure that you select only one response to each question.

Over the past 6 months:

- ___ A) How do you rate your confidence that you could get and keep an erection.
 1) Very low 2) Low 3) Moderate 4) High 5) Very high
- ___ B) When you had erections with sexual stimulation, how often were erections hard enough for penetration (entering your partner)?
 0) No sexual activity 1) Almost never or never 2) A few times-less than 1/2
 3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always
- ___ C) During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?
 0) Did not attempt intercourse 1) Almost never or never 2) A few times-less than 1/2
 3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always
- ___ D) During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
 0) Did not attempt intercourse 1) Extremely difficult 2) Very difficult
 3) Difficult 4) Slightly difficult 5) Not difficult
- ___ E) When you attempted sexual intercourse, how often was it satisfactory for you?
 0) Did not attempt intercourse 1) Almost never or never 2) A few times-less than 1/2
 3) Sometimes-1/2 the time 4) Most times-more than 1/2 5) Almost always