

NAME \_\_\_\_\_ Date of birth. \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ MOBILE \_\_\_\_\_

HOSPITAL FUND: Yes / No. Fund: \_\_\_\_\_ M/ship No: \_\_\_\_\_

Have you made any changes in the last 12 months? \_\_\_\_\_

PENSION No: \_\_\_\_\_ DVA Pens No: \_\_\_\_\_ Gold / White

PENSION EXP Date: \_\_\_\_\_

Medicare Number

Patient Number  Expiry /

MARITAL STATUS Single / Married / Divorced / Widowed / De-facto

OCCUPATION \_\_\_\_\_

What MEDICATIONS are you on currently? (Include over the Counter medications / vitamins)

\_\_\_\_\_  
\_\_\_\_\_

Are YOU allergic to any medications? YES/NO \_\_\_\_\_

Do you SMOKE? YES / NO / GIVEN UP – WHEN? \_\_\_\_\_

How much ALCOHOL do you drink in a DAY or in a WEEK? \_\_\_\_\_

Past ILLNESSES \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Past OPERATIONS \_\_\_\_\_

WHY ARE YOU HERE TODAY?

- |                                                         |                                                              |
|---------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Recurrent urinary infection    | <input type="checkbox"/> Blood in urine                      |
| <input type="checkbox"/> Poor bladder control (leakage) | <input type="checkbox"/> Frequency / Urgency                 |
| <input type="checkbox"/> Difficulty emptying bladder    | <input type="checkbox"/> Getting up at night                 |
| <input type="checkbox"/> Kidney stones                  | <input type="checkbox"/> Pain or burning when passing urine? |
| <input type="checkbox"/> Prostate Check / PSA           | <input type="checkbox"/> Other _____                         |

▪ How frequently (On Average) do you pass urine during the day?

- |                                          |                                     |                                     |
|------------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Every 4-6 hours | <input type="checkbox"/> 3-4 hours  | <input type="checkbox"/> 2-3 hours  |
| <input type="checkbox"/> 1-2 hours       | <input type="checkbox"/> every hour | <input type="checkbox"/> More often |

▪ How often (On Average) do you have to get up at night to pass urine?

- None     Once     Twice     3-4 times     More often

▪ When you pass urine, what is the flow like?

- Good stream     Fair stream     Poor stream     Varies a lot

- |                        |                              |                             |
|------------------------|------------------------------|-----------------------------|
| ▪ Delay in starting?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Stops and starts?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Dribbles afterwards? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

▪ Do you feel that you get your bladder empty when you pass urine?

- Yes     No     Sometimes doesn't empty     Don't know

▪ Any sexual problems?     Yes     No    Specify \_\_\_\_\_

▪ Do you have to go to the toilet URGENTLY when you want to go?  Yes     No

- |                     |                     |                              |                             |
|---------------------|---------------------|------------------------------|-----------------------------|
| ▪ Why is it urgent? | Pain or discomfort? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                     | Fear of leakage?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## International prostate symptom score (IPSS)

	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
<b>Incomplete emptying</b> Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
<b>Frequency</b> 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	
<b>Intermittency</b> 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	
<b>Urgency</b> Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
<b>Weak stream</b> Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
<b>Straining</b> Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	1 time	2 times	3 times	4 times	5 times or more	Your score
<b>Nocturia</b> Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

<b>Total IPSS score</b>	
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Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally satisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

▪ Do you leak on the way to the toilet if you can't get there in time? [ ] Yes [ ] No

▪ Do you ever leak when you cough or sneeze or lift something? [ ] Yes [ ] No

▪ Have you ever had a

Bladder infection?	[ ] Yes	[ ] No
Kidney infection?	[ ] Yes	[ ] No
Prostate infection?	[ ] Yes	[ ] No
Sexual transmitted disease?	[ ] Yes	[ ] No

▪ Do you have any of the following conditions?

High blood pressure	[ ] Yes	[ ] No
Heart disease / Heart valve abnormality /Angina	[ ] Yes	[ ] No
Asthma / Bronchitis / Lung problems	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No
Bowel disease	[ ] Yes	[ ] No
Problems with the nervous system / spinal cord / MS	[ ] Yes	[ ] No
Easily bruise or bleed	[ ] Yes	[ ] No

▪ Any major illnesses in your family? (eg, stroke, cancer, heart disease) [ ] Yes [ ] No

Details \_\_\_\_\_

▪ Have you ever had problems with an anaesthetic? [ ] Yes [ ] No

\* Are you under the care of any other doctor, other than the one referring you? [ ] Yes [ ] No

Details:

\_\_\_\_\_  
\_\_\_\_\_

The Privacy Act (1998) requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's information. This practice will collect information that is necessary to properly advise and treat you. With your consent, this practice will use and disclose your information for purposes such as referral to other health care providers/hospitals, obtaining advice on treatment options, billing, medical defence insurance notification obligations or where legally required to produce records. You are entitled to access your files upon request. If you require further information, please discuss this during your consultation.

Please sign once you have read the above

Signature \_\_\_\_\_

Date \_\_\_\_\_