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?

[ ] Recurrent urinary infection
[ ] Poor bladder control (leakage)
[ ] Difficulty emptying bladder
[ ] Kidney stones
[ ] Prostate Check / PSA
[ ] Blood in urine
[ ] Frequency / Urgency
[ ] Getting up at night
[ ] Pain or burning when passing urine?
[ ] Other ____________________________

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

  [ ] Every 4-6 hours [ ] 3-4 hours [ ] 2-3 hours

  [ ] 1-2 hours [ ] every hour [ ] 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? [ ] Yes [ ] No
- Stops and starts? [ ] Yes [ ] No
- Dribbles afterwards? [ ] Yes [ ] 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? [ ] Yes [ ] No

  Fear of leakage? [ ] Yes [ ] No

- 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____

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- 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:

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The Privacy Act (1998) requires medical practitioners to obtain consent form 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___________________