AUA SYMPTOM SCORE

Last Name	First Name	Date

Please complete the questions below by choosing your response level and then putting the corresponding number in the blue box below that choice. *i.e. if your answer to question 1 is less than half the time enter the number 2 in the blue box. If it is almost always enter 5 in the blue box. Your scores will total automatically at the bottom. Complete the final question on how you feel by placing an X in the box next to the corresponding response.*

1. Incomplete emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

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
0	1	2	3	4	5	

2. Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

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
0	1	2	3	4	5	

3. Intermittency: Over the past month, how often have you found that you stopped and started again several times when you urinated?

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
0	1	2	3	4	5	

4. Urgency: Over the past month, how often have you found it difficult to postpone urination?

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
0	1	2	3	4	5	

5. Weak-stream: Over the past month, how often have you had a weak stream?

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
0	1	2	3	4	5	

6. Straining: Over the past month, how often have you had to push or strain to begin urination?

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
0	1	2	3	4	5	

7. **Nocturia: Over the past month or so, how many times did you get up to urinate at night from the time you went to bed until the time you got up in the morning?**

0	1	2	3	4	5+ times	Your Score
0	1	2	3	4	5	

TOTAL AUA 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? *Place an X in the box next to the corresponding response.*

◯ Delighted ◯ Pleased ◯ Mostly satisfied ◯ Mixed ◯ Mostly dissatisfied ◯ Unhappy ◯ Terrible

PERSONAL MEDICAL HISTORY	FAMILY MEDICAL HISTORY	
Please check all that apply to you:	*Please check all that apply to your parents:*	
	MOTHER	*FATHER*
Diabetes ☐	☐	☐
High Blood Pressure ☐	☐	☐
Heart Attack ☐	☐	☐
Pacemaker ☐	☐	☐
Stroke ☐	☐	☐
Bleeding Problems ☐	☐	☐
Heart Disease ☐	☐	☐
Asthma ☐	☐	☐
Emphysema ☐	☐	☐
Kidney Disease ☐	☐	☐
Liver Disease ☐	☐	☐
HIV/AIDS ☐	☐	☐
Seizures ☐	☐	☐
Cancer ☐ If so, what type?	☐	☐

Cigarettes? # packs/day ☐ Previously ☐ Never ☐

Alcohol? # drinks/day ☐

Caffeine? # drinks/day ☐

Allergies: (list all medications, anesthetics, contrast agents, etc.)

REVIEW OF SYSTEMS

Do you have any problems now or have you had any related to the following systems? Indicate Yes or No

CONSTITUTIONAL SYMPTOMS	YES	NO
Fever	○	○
Chills	○	○
Weight change	○	○
HEIGHT: WEIGHT:		
EYES		
Glaucoma	○	○
Cataracts	○	○
Blurry Vision	○	○
Double Vision	○	○
Comments?		
CARDIOVASCULAR		
Chest Pain	○	○
Heart Attack	○	○
Irregular Heartbeat	○	○
Ankle Swelling	○	○
High Blood Pressure	○	○
Angina	○	○
Congestive Heart Failure	○	○
Problem with Heart Valves	○	○
Rheumatic Fever	○	○
Comments?		
PSYCHOLOGICAL		
Anxiety	○	○
Depression	○	○
Difficulty Sleeping	○	○
Comments?		
GENITOURINARY		
Change in Stream	○	○
Nocturia (getting up at night)	○	○
Urinary Frequency (>8 times/day)	○	○
Dysuria (burning with urination)	○	○
Blood in Urine	○	○
Urinary Tract Infection	○	○
Kidney Stones	○	○
Urinary Leakage	○	○
Comments?		
ENDOCRINE		
Excessive Thirst	○	○
Too Hot/Cold	○	○
Thyroid Condition	○	○
Diabetes	○	○
Comments?		

MUSCULOSKELETAL	YES	NO
Muscle Weakness	○	○
Joint Pain (Swelling)	○	○
Arthritis	○	○
History of Orthopedic Surgery	○	○
Chronic Back Pain	○	○
Chronic Neck Pain	○	○
Comments?		
NEUROLOGICAL		
Tremors	○	○
Dizzy Spells	○	○
Numbness/Tingling	○	○
Stroke	○	○
Weakness	○	○
Difficulty Walking	○	○
Loss of Bowel Control	○	○
Comments?		
HEMATOLOGIC/LYMPHATIC		
Swollen Glands	○	○
Blood Clotting Problem	○	○
Easy Bleeding/Bruising	○	○
Anemia	○	○
Enlarged Lymph Nodes	○	○
Transfusion History	○	○
Immune Deficiency	○	○
Comments?		
RESPIRATORY		
Wheezing	○	○
Chronic Cough	○	○
Shortness of Breath	○	○
Emphysema	○	○
Exposure to Tuberculosis	○	○
Comments?		
GASTROINTESTINAL		
Abdominal Pain	○	○
Nausea/Vomiting	○	○
Indigestion/Heartburn	○	○
Constipation	○	○
Diarrhea	○	○
Bloody or Dark Stools	○	○
Change in Bowels	○	○
Comments?		

REVIEW OF SYSTEMS (CONTINUED)

SEXUAL HISTORY	YES	NO
Change in Sex Drive	○	○
Poor Sexual Performance/Lack of Erection	○	○

Have you had a PSA?

Date: _____ Result: _____

Have you had any of the the following prostate procedures? If yes, when?

- ☐ TURP _____
- ☐ Laser/Greenlight _____
- ☐ TUNA _____
- ☐ Microwave _____
- ☐ Urolift _____
- ☐ Prostatectomy _____
- ☐ Stent _____
- ☐ Other _____

Current Medications and Supplements

Medication Name	Dose	Frequency/Schedule

The IIEF-5 Questionnaire (SHIM)

1. How do you rate your confidence that you can get and keep an erection?

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?

3. During sexual intercourse, how often were you able to maintain an erection after you had penetrated your partner?

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Please total your score from above here: