

TODAY'S DATE: _____

LAST NAME: _____

FIRST NAME: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIPCODE: _____

HOME PHONE #: _____ GENDER: _____

CELL PHONE #: _____ AGE: _____

BIRTHDATE: MM/DD/YY _____

SOCIAL SECURITY #: _____ - _____ - _____

EMAIL ADDRESS: _____

SINGLE: _____ MARRIED: _____ OTHER: _____

EMERGENCY CONTACT

NAME #: _____

PHONE #: _____ RELATION: _____

CURRENT EMPLOYER: _____

WORK TELEPHONE #: _____

PRIMARY INSURER'S / SPOUSE:

NAME: _____ BIRTHDATE: _____

SOCIAL SECURITY #: _____ - _____ - _____

REFERRING DOCTOR: _____

REFERRING TELEPHONE #: _____

Do you currently smoke? NO YES

if YES, how many PACK(s) per day?

1/2 pack 1 pack 2 packs 3 packs

How long have you been smoking for? _____

Did you ever smoke before? NO YES

if YES, when did you quit smoking? _____

How long did you smoke for? _____

How many PACK(s) per day?

1/2 pack 1 pack 2 packs 3 packs

Language: Please circle OR specify language.

English Spanish Chinese Other: _____

WEIGHT: _____ LBS HEIGHT: _____

BLOOD PRESSURE: _____ / _____ PULSE: _____

UA: Blood _____ Protein _____ Nitrate _____ Glucose _____

PHARMACY NAME: _____

ADDRESS: _____

TELEPHONE #: _____

Do you have any medication allergies?

NO YES

if YES, list them. _____

Are you currently taking any medications? NO YES

if YES, please give ALL medications to receptionist or list them on the back of this page.

Please include all dosage/mg/ %.

Do you currently drink alcohol? NO YES

if YES, what do you drink? Beer Liquor Wine

if YES, how often do you drink? Please check or

____ Daily ____ Weekly ____ Monthly ____ Yearly

If YES, how many drinks each time? _____

Are you a Social Drinker? Light Drinker?

Moderate Drinker? or Excessive Drinker?

Did you ever drink in the past? NO YES

if YES, when did you stop drinking? _____

How long did you drink for? _____

How often did you drink? Please check or

____ Daily ____ Weekly ____ Monthly ____ Yearly

How many drinks each time? _____

Race: Please circle.

White Black/African-American Asian Eskimo

American Indian/Alaska Native Hispanic/Latino

Ethnicity: Please circle.

Hispanic or Latino Non-Hispanic/Latino

LIST YOUR CURRENT MEDICATIONS (IF ANY) :

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

INTERNATIONAL PROSTATE SYMPTOM SCORE (IPSS)

Name: _____ **Date:** _____

<p align="center">CIRCLE THE NUMBER THAT BEST APPLIES TO YOU FOR EACH QUESTION</p>	<p align="center">NOT AT ALL</p>	<p align="center">LESS THAN 1 TIME IN 5</p>	<p align="center">LESS THAN ½ THE TIME</p>	<p align="center">ABOUT ½ THE TIME</p>	<p align="center">MORE THAN ½</p>	<p align="center">ALMOST ALWAYS</p>	<p align="center">SCORE</p>
<p>1. INCOMPLETE EMPTYING Over the last month how, often have you had a sensation of not emptying your bladder completely after you finish urinating?</p>	0	1	2	3	4	5	
<p>2. FREQUENCY During the last month, how often have you had to urinate again less than two hours after you finished urinating?</p>	0	1	2	3	4	5	
<p>3. INTERMITTENCY During the last month, how often have you stopped and started again several times when you urinate?</p>	0	1	2	3	4	5	
<p>4. URGENCY During the last month, how often have you found it difficult to postpone urination?</p>	0	1	2	3	4	5	
<p>5. WEAK STREAM During the last month, how often have you had a weak urinary stream?</p>	0	1	2	3	4	5	
<p>6. STRAINING During the last month, how often have you had to push or strain to begin urination?</p>	0	1	2	3	4	5	
<p>7. NOCTURIA During the last month, how 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?</p>	NONE	1 TIME	2 TIMES	3 TIMES	4 TIMES	5 TIMES	

Total IPSS Score _____