MESA UROLOGISTS

If you are a women

Note at all	Occasionally	About once a day	About three times a day	About half the time	Almost Always	Score
Urgency- How often do you have a strong sudden urge to urinate that makes you fea you will leak urine if you can't get to a bathroom immediately?						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
Urgency Incontinence- How often do you leak urine after feeling an urge to go?						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
None	**Drops**	**1 Teaspoon**	**1 Tablespoon**	**1/4 Cup**	**Entire Bladder**	**Score**
Incontinence- How much urine do you think usually leaks?						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
1-6 times	**7-8 times**	**9-10 times**	**11-12 times**	**13-14 times**	**15 or more times**	**Score**
Frequency- How many times do you urinate during the day?						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
None	**1 times**	**2 times**	**3 times**	**4 times**	**5 times or more**	**Score**
Wake to urinate- How many times do you usually get up each night to urinate?						
○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	_____
					Your Total Score	_____
Quality of life due to urinary symptoms						
Delighted	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrilbe**	
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	_____

Patient: _____ Date: _____

Mesa Urologists, P.C.

Medical History Questionnaire Annual UPDATE

ALL UNANSWERED QUESTIONS WILL BE ASSUMED TO BE NEGATIVE

NEW HEALTH PROBLEMS none ☐	Since	NEW SURGERIES none ☐	Date
1)		1)	
2)		2)	
3)		3)	
4)		4)	
5)		5)	
NEW HOSPITALIZATION none ☐	**Date**	**NEW INJURIES** none ☐	**Date**
1)		1)	
2)		2)	
3)		3)	

List all drugs you presently use regularly or take occasionally

MEDICATION	Strength	Dose
If you have a pre-printed list of your current medication. we will be happy to make a copy		
1)		
2)		
3)		
4)		
5)		

NEW ALLERGIES

☐ No allergies known

Are you allergic to

☐ Penicillin ☐ Sulfa drugs

☐ Codeine or Morphine

☐ Latex ☐ Adhesive tape

☐ Lodine (shellfish, contrast)

List other allergies

1) _____

2) _____

3) _____

Please provide approximate date of the most recent events of the following if applicable:

Mammogram: _____

Colonoscopy: _____

Dexa Scan: _____

Bone Scan: _____

Flu vaccine: _____

Pneumonia vaccine: _____

Physician's Signature: _____ Date: _____

Patient Name: _____ Age: _____ Date: _____

Original Questionnaire Done: _____