

REVIEW OF SYSTEMS

Do you have any problems now or have you had any related to the following systems? Please check Yes (Y) or No (N)

Constitutional Symptoms Weight change <input type="checkbox"/> Y <input type="checkbox"/> N Chills <input type="checkbox"/> Y <input type="checkbox"/> N Fever <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Genitourinary Change in stream <input type="checkbox"/> Y <input type="checkbox"/> N Nocturia (getting up at night) <input type="checkbox"/> Y <input type="checkbox"/> N Urinary frequency >8 times/day <input type="checkbox"/> Y <input type="checkbox"/> N Burning with urination <input type="checkbox"/> Y <input type="checkbox"/> N Other:
Eyes Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N Cataracts <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Musculoskeletal Muscle weakness <input type="checkbox"/> Y <input type="checkbox"/> N Joint pain (swelling) <input type="checkbox"/> Y <input type="checkbox"/> N Other:
Cardiovascular Chest pain <input type="checkbox"/> Y <input type="checkbox"/> N Irregular heartbeat <input type="checkbox"/> Y <input type="checkbox"/> N Swelling in ankles <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Neurological Tremors <input type="checkbox"/> Y <input type="checkbox"/> N Dizzy spells <input type="checkbox"/> Y <input type="checkbox"/> N Numbness/tingling <input type="checkbox"/> Y <input type="checkbox"/> N Stroke <input type="checkbox"/> Y <input type="checkbox"/> N
Psychologic Do you feel depressed? <input type="checkbox"/> Y <input type="checkbox"/> N Do you feel anxious? <input type="checkbox"/> Y <input type="checkbox"/> N	Respiratory Wheezing <input type="checkbox"/> Y <input type="checkbox"/> N Frequent cough <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> N Other:
Endocrine Excessive thirst <input type="checkbox"/> Y <input type="checkbox"/> N Too hot/cold <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Gastrointestinal Abdominal pain <input type="checkbox"/> Y <input type="checkbox"/> N Nausea/vomiting <input type="checkbox"/> Y <input type="checkbox"/> N Indigestion/heartburn <input type="checkbox"/> Y <input type="checkbox"/> N Constipation/diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N
Hematologic/Lymphatic Swollen glands <input type="checkbox"/> Y <input type="checkbox"/> N Blood clotting problem <input type="checkbox"/> Y <input type="checkbox"/> N Bruising <input type="checkbox"/> Y <input type="checkbox"/> N Other:	Sexual History Change in sex drive? <input type="checkbox"/> Y <input type="checkbox"/> N Sexual performance satisfactory? <input type="checkbox"/> Y <input type="checkbox"/> N Other:

Male Only	AUA Symptom Score: Circle one number in each line						
<i>Questions to be answered</i>	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	
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5	
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5	
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5	
Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	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
Sum the seven circled numbers (AUA Symptom Score):	Scoring: Mild 0 - 7		Moderate 8 - 19		Severe 20 - 35		

Physician Signature: _____ Date: _____