

# GEORGIA

## PROSTATE INSTITUTE

### PAE HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record.

<b>Name</b> (Last, First, M.I.):	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<b>How did you hear about us?</b> <input type="checkbox"/> Dr. Referred <input type="checkbox"/> Internet <input type="checkbox"/> Radio <input type="checkbox"/> Family/Friend <input type="checkbox"/> Other	
<b>Referring Doctor:</b>	<b>Other:</b>
<b>Pharmacy:</b>	<b>Pharmacy #:</b>

HISTORY OF PRESENT ILLNESS: (check all that apply)	
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Slow or straining to void
<input type="checkbox"/> Poor stream strength	<input type="checkbox"/> Hesitancy in starting to urinate
<input type="checkbox"/> Urinary Intermittency	<input type="checkbox"/> Urinary Catheter
<input type="checkbox"/> Dribbling	<input type="checkbox"/> Incomplete voiding
<input type="checkbox"/> Complete inability to urinate	<input type="checkbox"/> UTIs (urinary tract infections)
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Diagnosed with BPH (Benign Prostatic Hyperplasia)
<input type="checkbox"/> History of prostate Nodule(s)	<input type="checkbox"/> History of prostatitis
<input type="checkbox"/> History of overactive bladder	<input type="checkbox"/> History of urethral narrowing (stenosis)
<input type="checkbox"/> History of prostate cancer	<input type="checkbox"/> History of bladder cancer
<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Prostate size _____
<input type="checkbox"/> Most Recent Prostate-Specific Antigen: _____	

# GEORGIA

## PROSTATE INSTITUTE

Associated symptoms		
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Suprapubic Pain	<input type="checkbox"/> Chills
<input type="checkbox"/> Fever	<input type="checkbox"/> Terminal Dribble	<input type="checkbox"/> Dysuria
<input type="checkbox"/> Abnormal bladder emptying	<input type="checkbox"/> Abnormal urinary frequency	<input type="checkbox"/> Hematuria
<input type="checkbox"/> Nocturia	<input type="checkbox"/> Urine odor	<input type="checkbox"/> Strain to void
<input type="checkbox"/> Urinary intermittency	<input type="checkbox"/> Abnormal urine stream	<input type="checkbox"/> Split urinary stream
<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Stress incontinence	<input type="checkbox"/> Urinary retention
<input type="checkbox"/> Urgency	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sexual Transmitted Disease
<input type="checkbox"/> Other: _____		

Prior Tests and Imaging		
<input type="checkbox"/> MRI	<input type="checkbox"/> CT Scan	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Biopsy	<input type="checkbox"/> Uroflowmetry (urodynamics)	<input type="checkbox"/> Post-void residual volume measurement
<input type="checkbox"/> Prostate Specific Antigen: _____		

Prior Treatments		
<input type="checkbox"/> None	<input type="checkbox"/> Medication	<input type="checkbox"/> Urolift
<input type="checkbox"/> Microwave thermotherapy	<input type="checkbox"/> Rezum (water vapor / steam therapy)	<input type="checkbox"/> TURP (Transurethral Resection of Prostate)
<input type="checkbox"/> Suprapubic catheter		

Duration (How long have you had these symptoms?)		
<input type="checkbox"/> Days _____	<input type="checkbox"/> Weeks _____	<input type="checkbox"/> Months _____
<input type="checkbox"/> Years _____	<input type="checkbox"/> Date of Diagnosis: _____	

# GEORGIA

## PROSTATE INSTITUTE

AGGRAVATING FACTORS		
<input type="checkbox"/> None	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Intercourse
<input type="checkbox"/> Tobacco use	<input type="checkbox"/> Spicy foods	<input type="checkbox"/> Atarax
<input type="checkbox"/> Acidic foods	<input type="checkbox"/> Carbonated beverages	<input type="checkbox"/> Caffeine
<input type="checkbox"/> 5-alpha-reductase inhibitor	<input type="checkbox"/> Activity	<input type="checkbox"/> Increased fluids

ALLEVIATING FACTORS		
<input type="checkbox"/> None	<input type="checkbox"/> Analgesics	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Alpha blockers (ex. Flomax, Xatral, Rapaflo)	<input type="checkbox"/> Alpha-reductase inhibitors (ex. Proscar, Avodart)	<input type="checkbox"/> Antispasmodics
<input type="checkbox"/> Fluid restrictions	<input type="checkbox"/> Bladder irrigation	<input type="checkbox"/> Antidepressants
<input type="checkbox"/> Prostatic Massage		

PAIN		
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate
<input type="checkbox"/> Severe	<input type="checkbox"/> Improving	<input type="checkbox"/> Worsening
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Current Pain (scale 1 – 10 with 1 being lowest and 10 highest): _____	

OTHER MEDICAL PROBLEMS		
<input type="checkbox"/> Heart disease / CAD	<input type="checkbox"/> Peripheral arterial disease	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer
<input type="checkbox"/> COPD	<input type="checkbox"/> Hole in heart / Patent foramen ovale	<input type="checkbox"/> Migraines
<input type="checkbox"/> Blood clot / DVT	<input type="checkbox"/> Pulmonary embolus / PE	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Blood clotting disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sexual Transmitted Disease	<input type="checkbox"/> Other

# GEORGIA

## PROSTATE INSTITUTE

SURGERIES:	
Year	Operation

FAMILY HISTORY:

MEDICATIONS:

MEDICATION ALLERGIES: <input type="checkbox"/> No known drug allergies. <input type="checkbox"/> IV contrast allergy

SOCIAL HISTORY					
Do you smoke		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Former smoker		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
If former smoker:		Years smoked?		Year quit?	
Packs per day?	<input type="checkbox"/> 0	<input type="checkbox"/> < 1	<input type="checkbox"/> 1-2	<input type="checkbox"/> 2-3	<input type="checkbox"/> > 3
Alcoholic drinks per day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1-2	<input type="checkbox"/> 2-3	<input type="checkbox"/> 3-4	<input type="checkbox"/> > 4
Occupation:					

# GEORGIA

## PROSTATE INSTITUTE

### CURRENT SYMPTOMS

<b>GENERAL</b>		<b>GASTROINTESTINAL</b>		<b>NEUROLOGIC</b>	
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Restless Legs
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Numbness or Tingling
<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Headaches (Migraines)
<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	Nausea and Vomiting	<input type="checkbox"/>	Dizziness / Lightheaded
<b>EYES</b>		<b>GENITOURINARY</b>		<input type="checkbox"/>	Difficulty Walking
<input type="checkbox"/>	Change in Vision	<input type="checkbox"/>	Increased Urination	<b>PSYCHIATRIC</b>	
<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Urinating at Night	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Pain	<input type="checkbox"/>	Bloody Urine	<input type="checkbox"/>	Anxiety
<b>EARS, NOSE, THROAT</b>		<input type="checkbox"/>	Pelvic Pain	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Heavy Periods	<input type="checkbox"/>	Thoughts of Suicide
<input type="checkbox"/>	Ear Pain	<b>MUSCULOSKELETAL</b>		<b>ENDOCRINE</b>	
<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	Frequent Thirst
<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	Leg Swelling	<input type="checkbox"/>	Frequent Urination
<b>CARDIOVASCULAR</b>		<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Brittle Hair
<input type="checkbox"/>	Chest Pain	<b>SKIN</b>		<input type="checkbox"/>	Crave Ice
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Wounds on Feet	<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	Prior DVT (Blood Clot)	<input type="checkbox"/>	Skin Changes	<b>OTHER</b>	
<input type="checkbox"/>	Heart Defect	<input type="checkbox"/>	Skin Rashes or Itching	<input type="checkbox"/>	
<b>RESPIRATORY</b>		<b>HEMATOLOGIC</b>		<input type="checkbox"/>	
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	

### International Prostate Symptom Score (IPSS)

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	+

**Total International Prostate Symptom Score = \_\_\_\_\_**

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

### Quality of Life (QoL)

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No
---------------------------------------------------	-----	----

Did these medications help your symptoms?(circle)									
1	2	3	4	5	6	7	8	9	10

No Relief

Complete Relief

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No
---------------------------------------------------------------------------------------------------------------------------------	-----	----