State the reason for your appointment today

____

During the past month	Never	Rare	Occasio nally	Half the time	Often	Always
How often do you have the sensation of not emptying you bladder completely?						
How often do you have to urinate again within 2 hours of urinating?						
How often have you stopped and started several times during urination?						
How often have you had difficulty in postponing urination?						
How often is the urinary stream weak?						
How often do you strain to begin to urinate?						
How many times do you get up to urinate at night?	0	1	2	3	4	5 or more
Do you have burning / pain upon urination?						
Do you have leakage of urine?						
Have you seen blood in your urine						

Force of urinary stream .. .. **GOOD FAIR BAD**
My weight is .... **INCREASING STABLE DECREASING**

Have you had any new illnesses since your last visit, if so please list:

____

Have you had any new illnesses in your family since your last visit, if so please list:

____

Please list the name and dosage of all of your medications including over the counter drugs.
(Use other side if necessary).

____

Do you have:

Fever	**NO**	**YES**	Shortness of breath	**NO**	**YES**
Backache	**NO**	**YES**	Chest pain	**NO**	**YES**
Weakness or Numbness of legs	**NO**	**YES**	Rash	**NO**	**YES**
Incontinence of stool	**NO**	**YES**	Swollen glands	**NO**	**YES**
Constipation	**NO**	**YES**	Sinus problems	**NO**	**YES**
Diarrhea	**NO**	**YES**	Swollen ankles	**NO**	**YES**

PATIENT NAME____ DATE________________