PATIENT IDENTIFICATION:

Name: (Last) _____ (First) _____(MI) _____

DOB (MMDDYY): _____ Ethnicity: _____ Sex: M or F Religious Preference: _____

Duty Phone (with prefix):_____ Home Phone (with prefix): _____

Cell Phone: _____ Email Address: _____

Marital Status: (Married) (Divorced) (Single) How many children do you have?_____

APO/FPO/ CFPO Address: _____

SPONSOR'S INFORMATION

Social Security Number: _____ - ____- _____ Unit Assigned To: _____

Rank: _____ Service: (Army) (Air Force) (Navy) (Marines) (DoD) (Other) _____

Duty Phone (with prefix): _____ Home Phone (with prefix):_____

To better assess your health, please indicate below if you have any significant medical problems or concerns:

Asthma Abnormal Bleeding Allergies Diabetes Drug Allergies Epilepsy

Heart Disease High Blood Pressure Latex Allergy Lung Disease Venereal Disease

Others: _____

Please list any previous surgical procedures and dates: _____

Please list all medications you are presently taking: See LRMC Memo 40-51 Medication Reconciliation Patient Questionnaire

List all prescription medications you are presently taking: See LRMC Memo Outpatient Medication Reconciliation Patient Questionnaire

Please list previous hospitalizations:_____

Do you or have you ever smoked: Y or N If yes, please circle: (cigarettes) (cigar) (pipes) (other): _____

How much? _____ How much daily? _____ How many years? _____

Do you drink alcohol? Y or N If yes, how much? _____ How often? _____

Do you drink caffeine? Y or N If yes, how much weekly? _____

List any medical problems that run in your family history: _____

****

FEMALE ONLY: How many times have you been pregnant? _____ How many miscarriages have you had? _____

Medication Reconciliation Patient Questionnaire

- Drug reactions

Name of Medication	Reaction	Treatment to resolve reaction

Please list ALL substances that were non-food or drink items consumed in the last 30 days.

- **Prescription Medications:** including inhalers, radiology contrasts, blood, IV solutions, eye drops, as needed mediations

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

- **Over the Counter Medications:** i.e. Cold/Flu, pain, headache, vitamins, diet related, sleep aids, stomach, diarrhea, constipation, sinus

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

- **Sports/Dietary Supplements & Herbals:** i.e. pills, powders, gels, teas, drinks, creams

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

Print Name: _____ Date of Birth: _____

Date of Appt: _____

Please use reverse side for additional listings

MEN'S HEALTH ASSESSMENT QUESTIONNAIRE

Name _____ *Date* _____

American Urological Association Symptom Index (AUA-SI)*[1]

Circle the answer that best describes your symptoms.

Urinary symptoms during the past month	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. How often have you had a sensation of not emptying your bladder completely?	0	1	2	3	4	5
2. How often did you urinate more than once within a 2-hour period?	0	1	2	3	4	5
3. How often have you stopped and started several times while urinating?	0	1	2	3	4	5
4. How often have you had difficulty postponing urination?	0	1	2	3	4	5
5. How often have you had a weak urinary stream?	0	1	2	3	4	5
6. How often did you strain to begin to urinate?	0	1	2	3	4	5

7. How many times did you get up during the night to urinate?	0 TIMES	1 TIME	2 TIMES	3 TIMES	4 TIMES	5 TIMES

Total Score: _____

BOTHER ASSESSMENT QUESTION

Overall, how bothersome has any trouble with urination been during the last month?

❑ *Not at all bothersome* ❑ *Bothers me a little* ❑ *Bothers me some* ❑ *Bothers me a lot*

FEMALE INCONTINENCE QUESTIONNAIRE

Patient Name:_____ **Date:** _____

Do you have leakage with:

Coughing or sneezing?	Yes_____ No _____
Lifting?	Yes_____ No _____
Active exercise? (running, intercourse, etc.)	Yes_____ No _____
Minimal exercise? (walking, light housework, etc.)	Yes_____ No _____
Sleeping?	Yes_____ No _____
Nervousness or increased anxiety?	Yes_____ No _____
Leakage unrelated to any cause?	Yes_____ No _____

Is your clothing: Damp: _____ Wet _____ or Soaking Wet? _____

For protection do you use: Kotex Pads:_____ Tissue _____ or Diapers? _____
How many protective pads do you use per day? _____
Are they damp _____ wet _____ or saturated_____ at each change?

Do you leave puddles of urine on the floor?	Yes_____ No _____
Do you lose urine by continuous dribbling?	Yes_____ No _____
Do you lose urine in small spurts?	Yes_____ No _____
If yes, is it related to physical activity?	Yes_____ No _____
When you have the desire to urinate, do you lose urine before you can get to the toilet?	Yes_____ No _____
Do you get a severe urge:	
In the cold weather?	Yes_____ No _____
With running water?	Yes_____ No _____
At the front door of your house or restroom?	Yes_____ No _____
Do you have pain over your bladder when you are full or get the strong urge?	Yes_____ No _____

How often do you pass urine during the day?
Every hour or less _____ , 1-2 hours _____, 2-3 hours _____, 3-4 hours _____, or greater than 4 hours_____

How often do you pass urine after going to bed? _____

Is the volume of urine you pass usually?
Large _____ Average _____ Small _____ or very Small _____

Do you empty your bladder frequently, before you experience the desire to pass urine just so that you will stay dry? Yes_____ No _____

Please describe in your own words any additional information regarding your leakage problem not asked above.