

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Prefix: \_\_\_\_\_

Marital Status (please circle): **Single / Married / Partnered / Widowed / Divorced** Sex (please circle): **Male / Female**

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

SS #: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email Address: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_ Street your pharmacy is on: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Do you have power of attorney? **Yes / No** If yes, person's name: \_\_\_\_\_ Person's #: \_\_\_\_\_

Do you have a living will? **Yes / No**

**SPOUSE (if applicable)**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Phone #: \_\_\_\_\_

**EMERGENCY CONTACT**

Name 1: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Name 2: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**INSURANCE (Please give your insurance card(s) to the receptionist)**

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ Relationship to insured (please circle): **Self / Spouse / Child / Other**

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ Relationship to insured (please circle): **Self / Spouse / Child / Other**

**REFERRAL INFORMATION**

Referred By: \_\_\_\_\_ Phone #: \_\_\_\_\_

**TODAY'S DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please describe the reason for today's visit: \_\_\_\_\_  
 \_\_\_\_\_

List Relevant Symptoms: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to any medications? **Yes / No** If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all of your current medications, dosage, frequency, and the reason for taking them.

Medication	Dose	Frequency	Reason for taking

Are you taking any blood thinners?

- Aspirin                       Coumadin (Warfarin)                       Vitamin E                       Xeralto  
 Plavix                           Fish Oil                                       Pradaxa                           None

Do you smoke or use tobacco products? **Yes / No** If yes, how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcoholic beverages? **Yes / No** If yes, how many drink per day? \_\_\_\_\_

Do you drink caffeine (soda, coffee, etc.)? **Yes / No** If yes, how many drink per day? \_\_\_\_\_

**PATIENT PAST MEDICAL HISTORY:** Please list any medical conditions either current or past.

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes - On insulin? Yes / No	<input type="checkbox"/> Cancer (please specify type)	<input type="checkbox"/> Hypertensions (High Blood Pressure)
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Dialysis
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Hepatitis: A / B / C	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Other:		

**PATIENT SURGICAL HISTORY:** Please list any surgeries you have had and the year they were performed.

Surgery	Year of Surgery

**FAMILY MEDICAL HISTORY:** Please list any medical conditions in your family and specify which family member.

Condition	Family Member	Condition	Family Member
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Prostate Cancer	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Cancer (please specify type)	
<input type="checkbox"/> Stroke		<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Alzheimer's		<input type="checkbox"/> Parkinson's	
<input type="checkbox"/> Heart Attack		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Dementia	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____	

**Review of systems:** Please check if you have any of these symptoms recently. Please check NONE if none of the symptoms are present.

<p><b>General</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight loss or gain</li> <li><input type="checkbox"/> Fever or chills</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Sleep Apnea</li> <li><input type="checkbox"/> Other: _____</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Eyes</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurry or double vision</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Neurologic</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Numbness/Tingling</li> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Paralysis/Weakness</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Endocrine</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> Tired/Sluggish</li> <li><input type="checkbox"/> Too hot/cold</li> <li><input type="checkbox"/> None</li> </ul>
<p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abdominal pain</li> <li><input type="checkbox"/> Nausea/Vomiting</li> <li><input type="checkbox"/> Stomach Ulcer</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Cardiovascular</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain or discomfort</li> <li><input type="checkbox"/> Heart trouble</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Heart murmur</li> <li><input type="checkbox"/> Irregular heart beat</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Dermatological (Skin)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> Skin lumps</li> <li><input type="checkbox"/> Psoriasis</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Musculoskeletal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Muscle or joint pain</li> <li><input type="checkbox"/> Back pain</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> None</li> </ul>
<p><b>Ear/Nose/Throat/Mouth</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Vertigo</li> <li><input type="checkbox"/> Hearing loss</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Respiratory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Frequent cough</li> <li><input type="checkbox"/> Coughing up blood</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Hematological/Lymphatic</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Swollen glands</li> <li><input type="checkbox"/> Blood clotting problems</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> None</li> </ul>	<p><b>Psychiatric</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Suicidal thoughts</li> <li><input type="checkbox"/> None</li> </ul>

**FEMALE PREGNANCY HISTORY:**

Number of Vaginal Deliveries: \_\_\_\_\_ Number of Caesareans: \_\_\_\_\_

**THINK YOU HAVE OVERACTIVE BLADDER (OAB)?**

Do you think you have Overactive Bladder? Millions of men and women live with Overactive Bladder. This quiz will help you measure which Overactive Bladder (OAB) symptoms you have and how severe those symptoms are. Base your answers on the past month.

(Circle the response that best answers each question)

Symptom Questions	Not at all	Occasionally	About once a day	About three times a day	About half the time	Almost always	SCORE
<b>1. Urgency</b> - How often do you have a strong, sudden urge to urinate that makes you fear you will leak urine if you can't get to a bathroom immediately?	0*	1	2	3	4	5	
<b>2. Urgency Incontinence</b> - How often do you leak urine after feeling an urge to go? (whether you wear pads/ protection or not)	0	1	2	3	4	5	
	None	Drops	1 tsp	1 tbsp	1/4 cup	Entire bladder	
<b>3. Incontinence</b> - How much urine do you think usually leaks? (whether you wear pads/ protection or not)	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	
<b>4. Frequency</b> - How often do you urinate during the day?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 times or more	
<b>5. Wake to urinate</b> - How many times do you usually get up each night to urinate, from when you went to bed until you got up in the morning?	0	1	2	3	4	5	
<b>Total symptom score</b> (Add score from all five questions)							

\*If you score 0 on question 1, you probably don't have OAB.

0 = no symptoms  
25 = most severe symptoms

Quality of Life Questions How much does this bother you:	I am not bothered at all					I am bothered a great deal	SCORE
<b>1b. Urgency</b> - a strong, sudden urge to urinate that makes you fear you will leak urine if you can't get to a bathroom immediately?	0	1	2	3	4	5	
<b>2b. Urgency Incontinence</b> - leaking after feeling an urge to go?	0	1	2	3	4	5	
<b>3b. Frequency</b> - urinating frequently	0	1	2	3	4	5	
<b>4b. Waking to urinate</b> - Waking from sleep to urinate?	0	1	2	3	4	5	
	I would not be bothered at all					I would be bothered a great deal	SCORE
<b>5b. Overall satisfaction</b> - 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	
<p><b>6b. How have your symptoms changed your life?</b> - Please let us know how your symptoms (urgency, frequency, urine leakage, and waking at night) have changed your life.</p> <p>Are your symptoms: (Please check all that apply)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Keeping you from getting a good night's sleep?</li> <li><input type="checkbox"/> Causing you to stay home more than you would like?</li> <li><input type="checkbox"/> Keeping you from social activities or entertainment (movies, concerts, etc.)?</li> <li><input type="checkbox"/> Causing you to exercise (walking, sports, etc.) less or limit your physical activity?</li> <li><input type="checkbox"/> Causing problems with friends or loved ones</li> <li><input type="checkbox"/> Keeping you from traveling, taking trips, or using public transit?</li> <li><input type="checkbox"/> Making you plan trips around your knowledge of public restrooms?</li> <li><input type="checkbox"/> Causing problems at work?</li> <li><input type="checkbox"/> Other ways your symptoms have changed your life: _____</li> </ul>							
<p><b>Score the "bother" questions (1b, 2b, 3b, 4b, 5b &amp; 6b) separately. Do not add them together.</b></p>							

*Even if you have mild symptoms, if they bother you enough to change your life, you and your healthcare professional should discuss what treatment options are available to you.*

### Instructions – How do I use this Quiz?

Read this list of questions and answer them. Then bring your completed quiz to your next visit with your healthcare professional. This can be an easy way to start talking about your symptoms. The questions will help measure which Overactive Bladder (OAB) symptoms you have and how much your symptoms bother you. The better your healthcare professional knows the level and impact of your symptoms, the better he or she can help you manage them.

### Scoring – What do my results mean?

For “Symptom Questions” (1 through 5):

Add 1 + 2 + 3 + 4 + 5 to get a score from 0 (no symptoms) to 25 (most severe symptoms).

### What your total “Symptom” score means:

The higher your score for questions 1-5 are, the more severe your OAB symptoms are. However, if your score for question 1 is 0, then you do not have the hallmark symptom of Overactive Bladder—strong sudden urges to urinate that you cannot ignore. The answers to the “Symptom” questions can help you and your healthcare professional understand which of your OAB symptoms are most severe.

### For “Quality of Life” Questions (1b, 2b, 3b, 4b, 5b, & 6b):

DO NOT add your “Quality of Life” scores together. Each “Quality of Life” question is scored separately.

### What your “Quality of Life” results mean:

Questions 1b, 2b, 3b, 4b, 5b, & 6b on this quiz help show how your symptoms impact your life. We hope this will help you start a discussion with your healthcare professional about your symptoms. Seeing how much your symptoms have changed your life can help your healthcare professional decide what treatment choices to offer. Even if you have mild symptoms, if they bother you enough to change your life, you and your healthcare professional should discuss what treatment options are available to you.

### What if I have other symptoms?

Please let your healthcare professional know about any other symptoms you may have. (For example, do you have urine leakage when sneezing or exercising? Do you have bladder pain? Do you have to strain to begin urinating?) This will help your healthcare professional figure out if your symptoms could be caused by something other than OAB. It will also help them offer the treatment choices that are best for you.

### Where can I find a healthcare professional?

If you need a healthcare professional, visit [www.UrologyHealth.org/FindAUrologist](http://www.UrologyHealth.org/FindAUrologist) to find a urologist near you. Choose “incontinence” as a “special interest area” to find urologists who said they are interested in helping patients who leak urine or have OAB.

## **[ItsTimeToTalkAboutOAB.org](http://ItsTimeToTalkAboutOAB.org)**

**To schedule an appointment with an Erlanger Urologist,  
call **423-778-5910** or visit **[Erlanger.org/urology](http://Erlanger.org/urology)**.**