Review of Systems

Do you now or have you had any problems related to the following systems? (Circle Yes or No)

Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other ____________________		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other ____________________		

Reproductive

Infertility	Y	N
Erection Problems	Y	N
Ejaculation Problems	Y	N
Children	Y	N
Other ____________________		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other ____________________		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other ____________________		

Gastrointestinal

Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/heartburn	Y	N
Other ____________________		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High Blood Pressure	Y	N
Other ____________________		

Integumentary

Skin rash	Y	N
Boils	Y	N
Peristent itch	Y	N
Other ____________________		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other ____________________		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other ____________________		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other ____________________		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other ____________________		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other ____________________		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other ____________________		

Physician use only: (Comments/Notes)

Physician:____________________ Date: ____ / ____ / ____

Patient Label placed here

Wake Specialty Physicians

Urology

Male Patient History Form

INTERNATIONAL PROSTATE SYMPTOM SCORE

	Not at all	Less than 1 time in 5	Less than half the time in 5	About half the time	More than half the time	Almost always	Your Score
1. **Incomplete emptying** 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. **Frequency** Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. **Intermittency** Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. **Urgency** Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. **Weak stream** Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. **Straining** Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. **Nocturia** Over the past month, 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	1 time	2 times	3 times	4 times	5 or more times	
	0	1	2	3	4	5	
Total I-PSS Score: ________________							
Quality of Life Due to Urinary Symptoms 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?	Delighted	Pleased	Mostly satisfied	Mixed - equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	

Patient Label
placed here

Wake Specialty Physicians
Urology
Male Patient History Form