

MEN  
UROLOGICAL WORK-UP

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

Name \_\_\_\_\_ Age \_\_\_\_\_ Family Doctor or  
Referring Physician \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

DRUG ALLERGIES \_\_\_\_\_

WHAT IS THE REASON THAT YOU ARE HERE? \_\_\_\_\_

Do you have family history of Cancer? Prostate, Bladder, Kidney----- Yes \_\_\_ No \_\_\_  
High Blood pressure? ----- Yes \_\_\_ No \_\_\_  
Do you smoke? ----- Yes \_\_\_ No \_\_\_  
Have you ever had? ----- High Blood pressure ----- Yes \_\_\_ No \_\_\_  
Kidney infections ----- Yes \_\_\_ No \_\_\_  
Kidney stones ----- Yes \_\_\_ No \_\_\_  
Bladder infections ----- Yes \_\_\_ No \_\_\_  
Prostate infections ----- Yes \_\_\_ No \_\_\_  
Other prostate troubles ----- Yes \_\_\_ No \_\_\_  
If so, what \_\_\_\_\_  
Urethral stricture ----- Yes \_\_\_ No \_\_\_  
Swelling of one testicle ----- Yes \_\_\_ No \_\_\_  
Or both ----- Yes \_\_\_ No \_\_\_  
Problem with infertility ----- Yes \_\_\_ No \_\_\_  
Number of children \_\_\_\_\_  
Number of children by prior marriage \_\_\_\_\_

What volume do you void each time - cup or more, 1/2 cup, few oz. Or less? \_\_\_\_\_

DO YOU HAVE TO:

Push to get the urine started (strain to pass your water)? ----- Yes \_\_\_ No \_\_\_  
Urinate more frequently than normal? ----- Yes \_\_\_ No \_\_\_  
Get up at night to urinate? ----- Yes \_\_\_ No \_\_\_  
If yes, circle number of times 1 2 3 4 5 6 7 or more  
Go immediately when you get the urge? ----- Yes \_\_\_ No \_\_\_  
During the day how often do you urinate? 1 2 3 4 5 6 7 or more

HAVE YOU HAD, OR DO YOU HAVE:

Take longer to empty the bladder than normal? ----- Yes \_\_\_ No \_\_\_  
A decrease in the size of your stream? (Stream weak) ----- Yes \_\_\_ No \_\_\_  
A feeling of not emptying your bladder? ----- Yes \_\_\_ No \_\_\_  
Trouble starting the stream? ----- Yes \_\_\_ No \_\_\_  
Wait for stream to start? ----- Yes \_\_\_ No \_\_\_  
Does the stream stop and go or come out in spurts? ----- Yes \_\_\_ No \_\_\_  
Dribbling at the end of the urination? ----- Yes \_\_\_ No \_\_\_  
Pain or burning with urination? ----- Yes \_\_\_ No \_\_\_  
If yes, during or after? (Circle one)  
Pain? Back \_\_\_\_\_ Abdomen \_\_\_\_\_ above the pubis or penis \_\_\_\_\_ Scrotum \_\_\_\_\_  
Blood in your urine? ----- Yes \_\_\_ No \_\_\_  
If yes, was it throughout the stream? ----- Yes \_\_\_ No \_\_\_  
At the beginning only? \_\_\_\_\_ at the end only? \_\_\_\_\_  
Bloody sperm? ----- Yes \_\_\_ No \_\_\_

Have you ever seen a Urologist or Kidney Specialist before? ----- Yes \_\_\_ No \_\_\_  
If so, Whom? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever had an IVP? (Kidney x-ray) ----- Yes \_\_\_ No \_\_\_

Have you ever had urinary surgery? ----- Yes \_\_\_ No \_\_\_  
If so, When? \_\_\_\_\_ For What \_\_\_\_\_