PATIENT NAME:_____ **DOB:** _____ **DATE:**_____

URINARY SYMPTOMS – MALE

CHIEF COMPLAINT:_____

_____

_____

DURATION OF VOIDING SYMPTOMS: _____

STREAM: WEAK _____ FAIR _____ STRONG _____

STRAINING TO VOID: YES _____ NO _____

FREQUENCY: YES _____ NO _____

DAYTIME: _____ NOCTURIA: _____

HESITANCY: YES _____ NO _____ INTERMITTENCY: YES _____ NO _____

INCOMPLETE EMPTYING: YES _____ NO _____ URGENCY: YES _____ NO _____

INCONTINENCE: YES _____ NO _____

TYPE:_____

DYSURIA: YES _____ NO _____ HEMATURIA: YES _____ NO _____

PREVIOUS HISTORY: YES _____ NO _____ PRIOR TREATMENT:_____

HISTORY OF UTI: _____

HISTORY OF STD: YES _____ NO _____ HISTORY OF STONE: YES _____ NO _____

HISTORY OF PROSTATE PROBLEMS: _____

FAMILY HX OF PROTATE CA: YES _____ NO _____

HX OF BOWEL PROBLEMS/SURGERY: _____

HX OF BACK PROBLEMS/SURGERY: _____

ANTIBIOTIC TREATMENT FOR PROBLEM IN LAST YEAR:_____

_____ Patient verbalizes understanding of instructions given

Provider Signature: _____ Date: _____ Time: _____

Patient Name:

Date of Birth: