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Glens Falls, NY 12801
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Patient's Name _____ Date _____/_____/ 20___

Date of Birth _____

Urological History

Have you ever **NOTICED BLOOD** in your urine? N Y When: _____

Have you ever been **TOLD YOU HAVE BLOOD** in your urine? N Y When: _____

Have you ever had any kidney **KIDNEY STONES**? N Y When: _____

Have you ever had a **URINARY TRACT INFECTION**? N Y When: _____

If yes, how many and how was it treated (list antibiotics)? _____

How often at night do you **AWAKEN to URINATE**? 0 1 2 3 4 5 6 7 8 9

How often do you urinate **DURING the DAY**? 0 1 2 3 4 5 6 7 8 9

Do you experience **BURNING** upon urination? N Y Explain _____

Do you experience any **PAIN** upon urination? N Y Explain _____

Do you **LEAK URINE** or wet the bed? N Y Explain_____

Do you experience a sense of **URGNECY** to urinate? N Y Explain _____

Do you **STRAIN or PUSH** to urinate? N Y Explain _____

Do you experience a sense of **HESITANCY** to urinate? N Y Explain _____

Do you have a **SLOW or DRIBBLING** stream? N Y Explain _____

Have you been treated by **ANOTHER UROLOGIST** for this? N Y When _____

If so, for what condition and when? _____

Have you ever been treated by **ANOTHER UROLOGIST**? N Y

If so, for what condition and when? _____

Have you previously been seen in our office or hospital by our staff? N Y When _____

MEN, do you experience any problems with **ERECTIONS**? N Y Explain _____

If so, would you like any **TREATMENT/EVALUATION**? N Y Explain _____

Have you had the following, if so, when?

URINALYSIS _____	IVP _____	URODYNAMIC STUDIES _____
CULTURE _____	ULTRASOUND	CMG _____
CYTOLOGY _____	Renal _____	Flow _____
CBC _____	Bladder _____	UPP _____
PSA _____	Prostate _____	PVR _____
BUN/CREAT _____	RENAL SCAN _____	VLPP _____

Physician's Signature _____ Date: _____