Please complete ALL areas below. If not applicable please mark N/A.

PATIENT INFORMATION SHEET

DATE: _____

TITLE: _____ FIRST NAME: _____ SURNAME: _____

ADDRESS: _____

DATE OF BIRTH ____/____/_____ TELEPHONE: Home: (____) _____

Work: _____ Mobile: _____ Email: _____

OCCUPATION: _____ Marital Status: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

TELEPHONE: (____) _____

MEDICARE NO __ __ __ __ __ __ __ __ __ __ REF NO: ____ EXPIRY DATE: ____/____

PRIVATE HEALTH FUND: _____ MEMBERSHIP NO: _____

LEVEL OF COVER ie. EXTRAS_____ HOSPITAL COVER_____

PENSION CARD TYPE & NO: _____ Expiry Date: ____ /____ /____

DEPT OF VETERANS AFFAIRS NO: _____ Card Colour: _____

Referring Doctor: _____ Suburb: _____

GP (Family Doctor): _____ Suburb: _____

DRUG ALLERGIES – Please list All Drug Allergies: _____

MEDICAL HISTORY - (Please circle) Diabetes Asthma Heart Disease Chest pain Blood Pressure

MEDICATIONS – Please list medications you are currently taking: _____

_____

Previous Operations: Please list: _____

_____

WORKER'S COMPENSATION – EMPLOYER: _____

INSURANCE: _____ CLAIM NO: _____

Request and Disclosure of Information

I hereby give my permission for Urology Sydney to discuss and to seek medical information from any medical practitioner, who has referred, treated or will treat me as long as the exchange of information is necessary for my medical treatment. Please discuss this with your doctor if you are uncomfortable with any of the above issues.

Name: _____ Date: ____/____/____

Signature: _____ **NB. Please complete the back of this form.**

UROLOGY SYDNEY
Level 1, St George Medical Centre
1 South Street
Kogarah NSW 2217
Ph: 9587 4888
Fax: 9587 4899

SYMPTOM SCORE SHEET

STICKER

Surname: ……..

Given Names: ……..

Date of Birth: ……...

Date: ……

Age Group:

20 – 29 ❑ 30 – 39 ❑
40 – 49 ❑ 50 – 59 ❑
60 – 69 ❑ 70 + ❑

	Not at all	Less than 1 time in 5	Less than half the time	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 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 0	1 time 1	2 times 2	3 times 3	4 times 4	5 or more times 5	

TOTAL SYMPTOM SCORE ☐

Which of the above do you regard as most troublesome? (1-7) ☐

	Delighted	Pleased	Mostly Satisfied	Mixed satisfied & dissatisfied	Mostly dissatisfied	Unhappy	Terrible
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?	0	1	2	3	4	5	6