Over 10 years of caring
Dayton Physicians *Network*
Urology & Robotics

Patient's Name: ______________________ Date: ______________

What is the reason for today's visit? ______________________

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Please list your medications:	Please list your allergies:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Have you had any recent surgery or developed any new medical problems since your last visit? ☐ YES ☐ NO
If yes, please explain: ______________________

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SINCE YOUR LAST VISIT: **CIRCLE YOUR SCORE:**

1. INCOMPLETE EMPTYING: In a 24-hour period, how often have you had a sensation of not emptying your bladder?	0 times	1 time	2 times	3 times	4 times	5 times	
2. FREQUENCY: In a 24-hour period, how often have you had to urinate again less than 2 hours after you finished urinating?	0 times	1 time	2 times	3 times	4 times	5 times	
3. INTERMITTENCY: In a 24-hour period, how often have you found that you stopped and started again several times when you urinated?	0 times	1 time	2 times	3 times	4 times	5 times	
4. URGENCY: In a 24-hour period, how often do you find it difficult to postpone urination?	0 times	1 time	2 times	3 times	4 times	5 times	
5. WEAK STREAM: In a 24-hour period, how often do you have a weak urinary stream?	0 times	1 time	2 times	3 times	4 times	5 times	
6. STRAINING: In a 24-hour period, how often have you had to push or strain to begin urination?	0 times	1 time	2 times	3 times	4 times	5 times	
7. NOCTURIA: How many times do you get up to urinate from the time you go to bed at night until the time you get up in the morning?	0 times	1 time	2 times	3 times	4 times	5 times	
TOTAL SCORE: ______________________							

Dr. Signature: ______________________

Date: ______________________

Patient Signature: ______________________

Date: ______________________

We're here for you