EL CAMINO UROLOGY MEDICAL GROUP
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Over the past month, typically how often have you experienced:	Not at all	Less than 1 time in 5.	Less than half of the time.	About half of the time.	More than half of the time.	Almost Always.
INCOMPLETE EMPTYING A sensation of not emptying your bladder completely after you finished urinating.	0	1	2	3	4	5
FREQUENCY Urinating again less than 2 hours after you finished urinating.	0	1	2	3	4	5
INTERMITTENCY Stopping and starting again several times when you urinate.	0	1	2	3	4	5
URGE TO URINATE Finding it difficult to postpone urination.	0	1	2	3	4	5
WEAK STREAM Minimal urinary stream.	0	1	2	3	4	5
STRAINING Needing to push or strain to begin urination.	0	1	2	3	4	5
URINATING AT NIGHT Number of times you typically get up to urinate from the time you went to bed at night until the time you got up in the morning.	0	1	2	3	4	5

How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
	0	1	2	3	4	5	6

Gynecologic / Obstetric History

Menstrual History:

Age at First Menses _____
Currently menstruating? YES or NO
If YES, are periods regular? YES or NO
Spacing of periods: _____ Duration of Bleeding: _____
If NO, when did periods stop? _____
Menopause or Hysterectomy?
Date of last PAP smear: _____ Any abnormal PAP smears? YES or NO
If YES, specify: _____

Obstetric History:

Total pregnancies: _____ Vaginal deliveries: _____ C-sections: _____ Abortions: _____ Miscarriage: _____
Complicated deliveries? YES or NO
If YES, specify: _____

What is your main concern that you would like the doctor to address?

Patient Name: _____

Today's Date: _____ **MD Initials:** _____ **Date:** _____