BAY AREA UROLOGY ASSOCIATES
H. R. WAGNER, M. D., F.A.C.S.

8 PROFESSIONAL PARK DRIVE
WEBSTER, TEXAS 77598
Office 281-332-9502
Fax 281-332-6123

Date: _____ Referring Physician_____

LAST NAME_____ FIRST_____ MIDDLE_____

DATE OF BIRTH _____/_____/_____ Last 4 Social Security# ___ ___ ___ ___

CHIEF COMPLAINT_____
What is the main reason for your visit today? (Describe your problem in detail)

_____
_____
_____
_____
_____

History of Present Illness

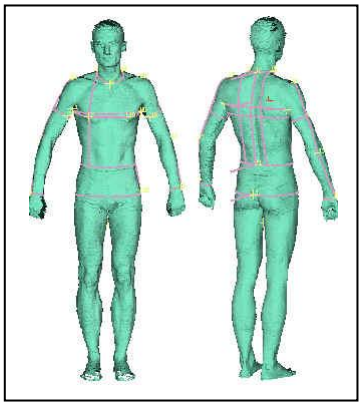
Please answer the following questions

Location of the problem
_____
_____

On a scale of 1-10, with 10 being the most severe,
Circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

Mark location ⇒



When did you first notice the problem?
_____

Does anything help or make the problem worse??
_____

Recent x-rays
or Blood tests?
which ones_____

Social History

Occupation_____
Status: ☐ Single ☐ Married / How long?_____ ☐ Divorced ☐ Separated ☐ Widowed
Do you smoke? ☐ No ☐ Yes If yes, how much?_____ How long have you smoked?_____

If previous smoker, how much?_____ pack / day Year stopped:_____

Do you drink alcohol? ☐ No ☐ Yes, If yes, how much? _____ per day_____

Recreational drug use? ☐ No ☐ Yes _____ Caffeine intake? No Yes, if yes, how much_____daily

Family History: Mother ☐ Alive / age _____ ☐ Deceased / at age _____ Died from_____

Father ☐ Alive / age_____ ☐ Deceased / at age _____ Died from _____
Please list number of siblings and ages: ☐ Sisters _____/_____/_____/_____ ☐ Brothers _____/_____/_____/_____/

Please list any family cancer or disease(s) and whom: _____
_____

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MALE PATIENTS

Describe your voiding over the past month. Circle how often have you had the following symptoms.

PROSTATE SYMPTOM SCORE	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
Incomplete Emptying – having the sensation of not emptying completely	0	1	2	3	4	5
Frequency – having to urinate again less than 2 hours after you finished urinating	0	1	2	3	4	5
Intermittency – having to stop and start again several times while urinating	0	1	2	3	4	5
Urgency – having difficulty postponing urination	0	1	2	3	4	5
Weak Stream – noticed a weak urinary stream	0	1	2	3	4	5
Straining – having to push or strain to begin urination	0	1	2	3	4	5

Total: _____

Do you have any concerns or questions regarding erectile dysfunction (ED)? ☐ Y ☐ N
Do you have any concerns or questions regarding low testosterone (LOW-T)? ☐ Y ☐ N

Explain_____

FEMALE PATIENTS

Problems with urinary control? ☐ Y ☐ N For how long _____
Do you leak with cough or activity? ☐ Y ☐ N How much _____
Do you have to wear any protective pads? ☐ Y ☐ N How many per day_____
Do you urinate frequently? ☐ Y ☐ N How often_____
If you have an urge to urinate, can you hold it? ☐ Y ☐ N Any accidents_____
Number of children by vaginal delivery? _____
Explain_____
_____
_____

SURGICAL HISTORY

Please check any of the following procedures you have had performed and the date of the procedure.

			FEMALES ONLY	MALES ONLY
☐ Adrenalectomy	☐ Cystoscopy	☐ Liver biopsy	☐ Bladder removal	☐ Bladder removal
☐ Appendectomy	☐ ESWL	☐ Kidney removed	☐ Bladder suspension	☐ Brachytherapy
☐ Back Surgery	☐ Gastricbypass	☐ Pacemaker	☐ Breast biopsy	☐ Circumcision
☐ Bladder augument	☐ Hernia repair	☐ Perc stoneremoval	☐ C-section	☐ Hernia repair
☐ CABG	Type:_____	☐ Kidney stone removal	☐ Abd hysterectomy	☐ Hydrocelectomy
☐ Gall bladder		☐ Ureteral stents	☐ Mastectomy	☐ Laser of prostate photoselective vaporization of prostate
☐ Colectomy	☐ Hip replacement ☐ L ☐ R	Date Placed: _____ For:_____		
☐ Colon surgery	☐ Knee ☐ L ☐ R replacement	☐ Radical Nephrectomy L R	☐ TAH / BSO	☐ Orchiectomy ☐ Penile prosthesis
☐ Coronary stent	☐ Laparoscopy		☐ Tubal ligation	☐ Prostate biopsy ☐ Radical prostatectomy
	☐ Lithotripsy		☐ Vaginal hysterectomy	☐ Spermatocelectomy ☐ TURP
			☐ Vaginal sling	☐ Varicocelectomy
				☐ Vasectomy

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