Review of Systems

Do you now or have you had any problems related to the following systems?
Circle **Yes** or **No**

Patient Name_____
Date_____

Constitutional Symptoms			**(Dr. Comments)**
Weight change	Y	N	
Chills	Y	N	
Fever	Y	N	
Other			

Eyes			
Glaucoma	Y	N	
Cataracts	Y	N	
Other			

Cardiovascular			
Chest pain	Y	N	
Irregular heartbeat	Y	N	
Swelling in ankles	Y	N	
Other			

Endocrine			
Excessive thirst	Y	N	
Too hot/cold	Y	N	
Other			

Hematologic/Lymphatic			
Swollen glands	Y	N	
Blood clotting problem	Y	N	
Bruising	Y	N	
Other			

Physician Comments:

Genitourinary			**(Dr. Comments)**
Change in stream	Y	N	
Nocturia (getting up at night)	Y	N	
Urinary frequency > 8 times/day	Y	N	
Burning with urination	Y	N	
(Dr. USI Form Completed?)	Y	N	
Other:			

Musculoskeletal			
Muscle weakness	Y	N	
Joint pain (swelling)	Y	N	
Other			

Neurological			
Tremors	Y	N	
Dizzy spells	Y	N	
Numbness/tingling	Y	N	
Stroke	Y	N	

Respiratory			
Wheezing	Y	N	
Frequent cough	Y	N	
Shortness of breath	Y	N	
Other			

Gastrointestinal			
Abdominal pain	Y	N	
Nausea/vomiting	Y	N	
Indigestion/heartburn	Y	N	
Constipation/Diarrhea	Y	N	

Sexual History			
Change in sex drive?	Y	N	
Sexual performance satisfactory?	Y	N	
(Dr. ED Form Completed?)	Y	N	

MALES ONLY

AUA Symptom Score: Circle one number on each line

Questions to be answered by males only:	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
1. 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. Over the past month, how often have you had to urinate less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. On a nightly basis, how many times do you typically get up to urinate?	0	1	2	3	4	5

Quality of Life Due to Urinary Symptoms	*Delighted*	*Pleased*	*Mostly Satisfied*	*Mixed*	*Mostly Dissatisfied*	*Unhappy*	*Terrible*
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Sum the seven circled numbers (AUA Symptom Score): _____ Scoring: Mild: 0 – 7 Moderate: 8 to 19 Severe: 20 – 35

Physician Signature:_____ Date_____

Patient Name:_____ Date_____