NAME _____Date of birth. _____/_____/____

ADDRESS _____

TELEPHONE: (H) _____ (W) _____ MOBILE _____

HOSPITAL FUND: Yes / No. Fund: _____ M/ship No: _____

Have you made any changes in the last 12 months? _____

PENSION No: _____ DVA Pens No: _____Gold / White

PENSION EXP Date: _____

Medicare Number ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Patient Number ☐ Expiry /

MARITAL STATUS Single / Married / Divorced / Widowed / De-facto

OCCUPATION _____

What MEDICATIONS are you on currently? (Include over the Counter medications / vitamins)

_____

_____

Are YOU allergic to any medications? YES/NO _____

Do you SMOKE? YES / NO / GIVEN UP – WHEN? _____

How much ALCOHOL do you drink in a DAY or in a WEEK? _____

Past ILLNESSES _____

_____

_____

Past OPERATIONS _____

_____

WHY ARE YOU HERE TODAY?

[ ]	Recurrent urinary infection	[ ]	Blood in urine
[ ]	Poor bladder control (leakage)	[ ]	Frequency / Urgency
[ ]	Difficulty emptying bladder	[ ]	Getting up at night
[ ]	Kidney stones	[ ]	Pain or burning when passing urine?
[ ]	Prostate Check / PSA	[ ]	Other _____

- How frequently (On Average) do you pass urine during the day?

  [ ] Every 4-6 hours [ ] 3-4 hours [ ] 2-3 hours

  [ ] 1-2 hours [ ] every hour [ ] More often

- How often (On Average) do you have to get up at night to pass urine?

[ ] None [ ] Once [ ] Twice [ ] 3-4 times [ ] More often

- When you pass urine, what is the flow like?

  [ ] Good stream [ ] Fair stream [ ] Poor stream [ ] Varies a lot

- Delay in starting? [ ] Yes [ ] No
- Stops and starts? [ ] Yes [ ] No
- Dribbles afterwards? [ ] Yes [ ] No

- Do you feel that you get your bladder empty when you pass urine?

  [ ] Yes [ ] No [ ] Sometimes doesn't empty [ ] Don't know

- Any sexual problems? [ ] Yes [ ] No Specify _____
- Do you have to go to the toilet URGENTLY when you want to go? [ ] Yes [ ] No
- Why is it urgent? Pain or discomfort? [ ] Yes [ ] No

  Fear of leakage? [ ] Yes [ ] No

- Do you leak on the way to the toilet if you can't get there in time? [ ] Yes [ ] No

- Do you ever leak when you cough or sneeze or lift something? [ ] Yes [ ] No

- Have you ever had a
  - Bladder infection? [ ] Yes [ ] No
  - Kidney infection? [ ] Yes [ ] No
  - Prostate infection? [ ] Yes [ ] No
  - Sexual transmitted disease? [ ] Yes [ ] No

- Do you have any of the following conditions?

High blood pressure	[ ] Yes	[ ] No
Heart disease / Heart valve abnormality /Angina	[ ] Yes	[ ] No
Asthma / Bronchitis / Lung problems	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No
Bowel disease	[ ] Yes	[ ] No
Problems with the nervous system / spinal cord / MS	[ ] Yes	[ ] No
Easily bruise or bleed	[ ] Yes	[ ] No

- Any major illnesses in your family? (eg, stroke, cancer, heart disease) [ ]Yes [ ] No

Details_____

_____

- Have you ever had problems with an anaesthetic? [ ] Yes [ ] No

* Are you under the care of any other doctor, other than the one referring you? [ ] Yes [ ] No

Details:

_____

_____

The Privacy Act (1998) requires medical practitioners to obtain consent form their patients to collect, use and disclose that patient's information. This practice will collect information that is necessary to properly advise and treat you. With your consent, this practice will use and disclose your information for purposes such as referral to other health care providers/hospitals, obtaining advice on treatment options, billing, medical defence insurance notification obligations or where legally required to produce records. You are entitled to access your files upon request. If you require further information, please discuss this during your consultation.

Please sign once you have read the above

Signature _____ Date_____