Urology Questionnaire

Year_____Month_____Day_____

Name	(Male/Female)	Birth Date Year_____Month_____Day_____ Nationality( ) Age ( )
Adress	〒	
Number		

◆What brought you here today?

☐difficulty urinating ☐frequent urination ☐urinary incontinence ☐slow stream

☐feeling of incomplete emptying ☐fever ☐pain when urinating ☐low back pain

☐bloody urine ☐sexually transmitted disease ☐genital abnormalities

☐abnormal medical examination(occult blood/proteinuria/PSA/others) ☐erectile dysfunction

☐decreased libido ☐late onset hypogonadism ☐others( )

◆How long have you had these problems? (Since Year_____Month_____Day_____)

◆What illnesses have you had in the past?

( )

◆Are you currently taking medication?

☐Yes ( ) ☐No

◆Do you have any food or medication allergies?

☐Yes ( ) ☐No

◆Have you ever had any operations?

☐Yes ( ) ☐No

◆Do you drink alcohol? ☐Yes ( ) ☐No

◆Do you smoke? ☐Yes ( ) ☐No

Only female

★Are you pregnant or is there a possibility of pregnancy? ☐Yes ☐No

★Are you currently breastfeeding? ☐Yes ☐No