Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

# Review of Systems

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

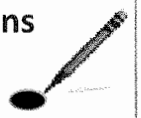
PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

## Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



## Please mark only the symptoms you CURRENTLY are experiencing.

**Mark all that apply ---- if no symptoms, please mark "NONE"**

| | | | |
|---|---|---|---|
| **General** | | | |
| | weight loss ◯ | fever ◯ | |
| fatigue ◯ | weight gain ◯ | persistent infections ◯ | NONE ◯ |
| **Eyes** | | | |
| | visual disturbances ◯ | glasses / contacts ◯ | NONE ◯ |
| **Ear, Nose, and Throat** | | | |
| | hearing loss ◯ | sinus pain ◯ | |
| | seasonal allergies ◯ | oral ulcers ◯ | NONE ◯ |
| **Cardiovascular** | | | |
| | chest pain ◯ | swelling hands / feet ◯ | |
| difficulty breathing on exertions ◯ | palpitations ◯ | shortness of breath ◯ | NONE ◯ |
| **Respiratory** | | | |
| | | chronic cough ◯ | |
| wheezing ◯ | difficulty breathing ◯ | coughing blood ◯ | NONE ◯ |
| **Breast** | | | |
| mass / lump ◯ | breast pain ◯ | nipple discharge ◯ | NONE ◯ |
| **Gastrointestinal** | | | |
| | constipation ◯ | bloody stool ◯ | |
| nausea ◯ | chronic diarrhea ◯ | hemorrhoids ◯ | |
| vomiting ◯ | abdominal pain ◯ | excessive gas ◯ | |
| change in bowel habits ◯ | jaundice ◯ | heartburn ◯ | |
| pain with swallowing ◯ | fecal incontinence ◯ | difficulty swallowing ◯ | NONE ◯ |
| **Female Genitourinary (Women Only)** | | | |
| | | blood in urine ◯ | |
| pelvic pain ◯ | vaginal dryness ◯ | painful urination ◯ | |
| urinary frequency ◯ | vaginal discharge ◯ | painful menstruation ◯ | |
| urinary urgency ◯ | vaginal itch or burning ◯ | menstrual irregularities ◯ | |
| excessive urination at night ◯ | painful intercourse ◯ | urine leakage ◯ | NONE ◯ |
| **Male Genitourinary (Men Only)** | | | |
| urine leakage ◯ | urinary frequency ◯ | testicular mass ◯ | |
| painful urination ◯ | urinary urgency ◯ | testicular pain ◯ | |
| change in urinary stream ◯ | impotence ◯ | penile lesions ◯ | |
| excessive urination at night ◯ | urethral discharge ◯ | blood in urine ◯ | NONE ◯ |
| **Musculoskeletal** | | | |
| joint pain ◯ | muscle pain ◯ | muscle weakness ◯ | NONE ◯ |
| **Skin** | | | |
| dry skin ◯ | rash ◯ | new sore / lesion ◯ | |
| change in wart or mole ◯ | hives ◯ | skin ulcer ◯ | NONE ◯ |
| **Neurologic** | | | |
| fainting ◯ | numbness ◯ | seizures ◯ | |
| decreased memory ◯ | trouble walking ◯ | headaches ◯ | NONE ◯ |
| **Psychiatric** | anxiety ◯ | frequent crying ◯ | |
| change in sleep pattern ◯ | depression ◯ | fearful ◯ | NONE ◯ |
| **Endocrine** | | cold intolerance ◯ | |
| hair changes ◯ | heat intolerance ◯ | hot flashes ◯ | NONE ◯ |
| **Heme/Lymphatic** | | | |
| easy bruising ◯ | excessive bleeding ◯ | gland problems ◯ | NONE ◯ |

# AUA BPH Symptom Score Questionnaire

Patient Name _____ Date of birth _____ Date completed:_____

| | Not at All | Less than 1 in 5 Times | Less than Half the Time | About Half the Time | More then Half the Time | Almost Always | Your Score |
|---|---|---|---|---|---|---|---|
| 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 again less than two hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 3. Over the past month, how often have you stopped and started again several times when you urinated? | 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, have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 | |
| | None | 1 Time | 2 Times | 3 Times | 4 Times | 5 or More | |
| 7. Over the past month, how many times did you most 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+ | |
| Total Symptom Score | | | | | | | |

Score: 1-7: Mild 8-19: Moderate 20-35: Severe

The possible total runs from 0 to 35 points with higher scores indicating more severe symptoms. Scores less than seven are considered mild and generally do not warrant treatment.

**Disclaimer: This material is provided for information purposes only and is not a substitute for a consultation. You should consult with a urologist regarding your specific symptoms.**