UROLOGY SPECIALISTS

201 W. 69th St.
Sioux Falls, SD 57108
(605) 336-0635

Patient Name: ______________________________ **Date of Birth:** _____________

Medications Trialed and Response: Have you tried this medication? Yes/No Place and "X" in appropriate box for response. Brand/Generic Drug Names			**How many month(s) did you trial/take this medication?**	**Did not help at all**	**Helped at first, but then stopped**	**Helped, but could not tolerate the side effects. List side effects**	**Helped and relieved ALL symptoms**
Flomax (Tamsulosin)	Yes	No					
Rapaflo (Silodosin)	Yes	No					
Avodart (Dutasteride)	Yes	No					
Proscar (Finasteride)	Yes	No					
Jalyn (Dutasteride/Tamsulosin)	Yes	No					
Uroxatral (Alfuzosin)	Yes	No					
Cardura (Doxazosin)	Yes	No					
Hytrin (Terazosin)	Yes	No					
Other(s) (Please list)	Yes	No					

Lifestyle Changes and Quality of Life Factors:	
If you use pads for leaking, how many pads are used in a 24 hour period?	1-3 pads 3-5 pads 5+ pads
Have you tried and failed any of the options here (check all that apply):	□ Medications □ Time voiding patterns □ Diet Modification (Limiting bladder irritants, low-fat diet, etc.) □ Fluid Management (Limiting fluids before bedtime/during day)
How do your symptoms negatively affect your quality of life?	□ Pain/Discomfort □ Interferes with exercise/activities that are important to me □ Affects my self-esteem/personal life/sexual life □ Affects my job □ Other:

Have you ever had any imaging of your prostate? Yes No If yes: Ultrasound MRI

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IPSS Survey: **Today's Date: ______________**

Please complete this survey to the best of your ability.
If you have questions, please discuss with nurse at your visit.
This information will be used by your provider to help us understand how your urinary symptoms and/or treatment change over time.

Determine your BPH Symptoms:

Circle your answers and add up your score

Over the past month…	**Not at all**	**Less than one time in five**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak Stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times do you typically get up to urinate from the time you went to bed at night until you got up in the morning?	None 0	1 Time 1	2 Times 2	3 Times 3	4 Times 4	5 or More Times 5
Add Symptom Scores:						

Total International Prostate Symptom Score = ______________

1 – 7 mild symptoms I 8-19 moderate symptoms I 20-35 severe symptoms

Regardless of the score, please discuss your symptoms with your physician.

Quality of Life:

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

Have you tried medications to help your symptoms? (Please elaborate on next page)	**YES**	**NO**
Did these medications help your symptoms? No relief/1 2 3 4 5 6 7 8 9 10/Complete Relief		
Do you have an allergy or sensitivity to NICKEL?	**YES**	**NO**

___________________________________ **Patient Signature**

Adapted from 2017 NeoTract Inc.

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