Patient Name:_____Date of Birth: _____

Constitutional Symptoms
Chills Y N

Eyes
Glaucoma Y N

Neurologic
Dizzy Spells Y N

Gastrointestinal
Constipation Y N
Diarrhea Y N

FEMALE ONLY

1. Do you leak urine (have accidents)?	☐ Yes	☐ No
a) Urinary leakage has been present for more than 6 months.	☐ Yes	☐ No
b) Do you wear pads?	☐ Yes	☐ No
c) Do you wear a thick pad (not a thin type)?	☐ Yes	☐ No
d) Are the pads soaked?	☐ Yes	☐ No
e) Do you have accidents when sleeping?	☐ Yes	☐ No
f) Do accidents occur when you get a strong urge to urinate?	☐ Yes	☐ No
g) Do accidents occur while coughing, sneezing, laughing or exercising?	☐ Yes	☐ No
2. Have you had surgery for urinary leakage?	☐ Yes	☐ No
3. I can wait three hours to urinate?	☐ Yes	☐ No
4. After I go to bed for the night I have to get up to urinate.	☐ Yes	☐ No
5. I start and stop multiple times while urinating.	☐ Yes	☐ No
6. I am straining with urination.	☐ Yes	☐ No
7. Do you feel like you empty your bladder?	☐ Yes	☐ No
8. Do you feel you have a weak stream?	☐ Yes	☐ No
9. I have a history of bladder / kidney infections?	☐ Yes	☐ No
10. I have a history of blood in my urine?	☐ Yes	☐ No
11. The number of 8oz glasses of fluids I drink a day is _____ cups (8oz) per day		
12. Are you pregnant?	☐ Yes	☐ No
13. Last menstrual cycle _____		

MALE ONLY

AUA Symptom Score: **Circle one number on each line**

Questions to be answered	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 experienced interrupted urination (stopped and started again)?	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

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