

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**.

Please explain any **Yes** answers in space provided.

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other: _____

Gastrointestinal

Abdominal Pain Y N
Nausea / Vomiting Y N
Indigestion/Heartburn Y N
Other: _____

Respiratory

Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other: _____

Eyes

Blurred Vision Y N
Double Vision Y N
Pain Y N
Other: _____

Cardiovascular

Chest Pain Y N
Varicose Veins Y N
High Blood Pressure Y N
Other: _____

Hematologic / Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Other: _____

Allergic / Immunologic

Hay Fever Y N
Drug Allergies Y N
Other: _____

Integumentary

Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other: _____

Psychologic

Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N

Neurological

Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other: _____

Musculoskeletal

Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other: _____

Male History

Difficulty with erections Y N
Discharge from penis Y N
Have you had venereal diseases? Y N
Have you had any prostate infections or prostatitis? Y N

Endocrine

Excessive thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Diabetes Y N
Other: _____

Ear/Nose/Throat/Mouth

Ear Infection Y N
Sore Throat Y N
Sinus Problems Y N
Other: _____

American Urological Association (AUA) Symptom Index¹

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 again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinate?	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. 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

Sum of seven circled number (AUA Symptom Score):

Scoring: Mild: 0-7 Moderate: 8 - 19 Severe: 20 - 35