UROLOGY, P.C.

5500 Pine Lake Road Lincoln, Nebraska 68516 (402) 489-8888 Fax (402) 421-1945

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**Patient Name:**   **DOB:**

**This form is required to be completed before we can proceed with scheduling.**

**Please circle all that apply.**

**Unable to urinate or empty your bladder (urinary retention)?** Yes No

Less than 6 months 6 months to 1 year Greater than 1 year

**Do you self-catheterize?** Yes No

How many times per day?

**Urgency/Frequency (have to go right away/often)?** Yes No

Less than 6 months 6 months to 1 year Greater than 1 year

**How many times do your urinate during the day? (Choose One)**

1-4 times 5-9 times 10-20 times 20-30 times

**Sudden urge to urinate causing leakage?** Yes No

Less than 6 months 6 months to 1 year Greater than 1 year

**If you use pads for protections, how many pads are used in a 24 hr period? (Choose One)**

1-3 pads 3-5 pads 5+ pads

**Please circle the treatments you have tried and indicate how long you tried them?**

Kegels Diet modification (bladder irritants, caffeine, etc.)

Biofeedback Fluid management (limiting fluids before bedtime)

Pelvic floor exercises None

**Patient signature:**   **Date:**



**Patient Name: DOB:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medications Trialed and Response**  Have you tried this medication? Circle Yes or No  Please place an “X” in appropriate box for response  Brand/Generic Drug Names | | | Did not help with symptoms at all | Helped at first,  then quit | Helped, but could not tolerate the side effects | Helped and relieved all symptoms |
| **Enablex**  (Darifenacin) | Yes | No |  |  |  |  |
| **Ditropan**  (Oxybutynin) | Yes | No |  |  |  |  |
| **Vesicare**  (Solifenacin) | Yes | No |  |  |  |  |
| **Sanctura**  (Trospium) | Yes | No |  |  |  |  |
| **Oxytrol**  (Oxybutynin) | Yes | No |  |  |  |  |
| **Toviaz**  (Fesoterodine) | Yes | No |  |  |  |  |
| **Detrol**  (Tolterodine) | Yes | No |  |  |  |  |
| **Flomax**  (Tamsulosin) | Yes | No |  |  |  |  |
| **Myrbetriq**  (Mirabegron) | Yes | No |  |  |  |  |
| **Gemtesa**  (Vibegron) | Yes | No |  |  |  |  |
| **Other(s)**  (Please list) | Yes | No |  |  |  |  |

**Patient Signature:** **Date:**