Are you experiencing any of these symptoms?	
Do you wake up at night to urinate? If yes, how many times?	[Yes|No] [___]
Do you void frequently during the day? If yes, how many times?	[Yes|No] [___]
Do you have to rush to get to the bathroom?	[Yes|No]
Do you have a slow/weak urine stream?	[Yes|No]
Do you have to wait for your pee to start?	[Yes|No]
Do you have to push/bear down for your pee to start?	[Yes|No]
Do you feel like you have some pee left in your bladder immediately after you pee?	[Yes|No]
Have you seen blood in your urine?	[Yes|No]
Have you ever had any pain in your pelvis/perineum?	[Yes|No]
Do you have a history of urinary tract infections? If yes, how many times/how often?	[Yes|No] [_____]
Do you have a history of kidney stones? If yes, how many times?	[Yes|No] [___]
Have you ever been unable to pee ? If yes when?	[Yes|No] [_____]
Have you ever had a catheter?	[Yes|No]

Do you take any medications? (Specially those that you're taking for peeing better/prostate pills)? (Please list all medications to the best of your ability, name, dosage, how long been on this medication)	
Medications Taken:	
Do you take any blood thinners?	[Yes|No]
Have you seen a urologist before? If yes, please explain why?	[Yes|No] [_____]
Have you ever had your PSA measured? If yes, when was it? What was the number?	[Yes|No]
Have you ever had a prostate biopsy? If yes, when was it? What were the results?	[Yes|No]
Have you ever had a prostate MRI? If yes, when was it?	[Yes|No]
Have you ever had a transrectal ultrasound of the prostate? If yes, when was it?	[Yes|No]
Have you had a previous cystoscopy? If yes: Date of procedure: Location of procedure: Results:	[Yes|No]
Do you smoke or use nicotine products on a daily basis: If yes: How many cigarettes per day? For how many years?	[Yes|No]

Have you been diagnosed or suspected to have any of the following?	
Kidney disease	[Yes|No|Unsure]
Sleep apnea If Yes, please indicate year of diagnosis	[Yes|No|Unsure]
Bleeding tendency If Yes: please indicate year of diagnosis	[Yes|No|Unsure]
Cancer If Yes: please indicate year of diagnosis and specify the type	[Yes|No|Unsure]
Neurological diseases (MS, Parkinson's disease, feeling weakness or numbness in your hands or feet)	[Yes|No|Unsure]
Accidents or injury to the spine	[Yes|No|Unsure]
Degenerative disc disease	[Yes|No|Unsure]
Diabetes Mellitus If Yes: please indicate year of diagnosis [on insulin|on pills|watching diet]	[Yes|No|Unsure]

Do you have a family history of (prostate/bladder/kidney cancer)? If Yes: please indicate relation, type of cancer and age at the diagnosis	[Yes|No]

How much fluid do you drink during the day (how many glasses or cups)? (Including water, juice, coffee, tea, pop, energy drinks)	[Yes|No]
How much of it is after 6 PM?	[Yes|No]