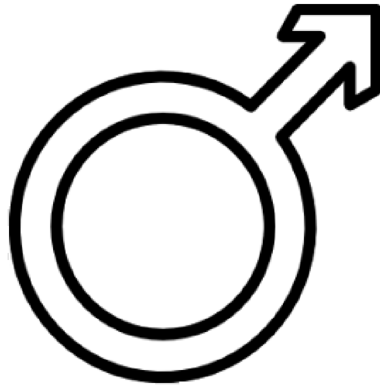


Male Patient

Paperwork for Urodynamics

CONSULTATION INFORMATION

www.urologyaustin.com

Patient Information Sheet and Instructions

IMPORTANT: Please call at least 24 hours in advance to cancel an appointment to prevent a cancellation fee.

General Questionnaire – The General Questionnaire should be filled out completely by all patients. You are correct that your chart and physician has the majority of the information, but the information is dispersed throughout the chart. Your answer to these questions and compilation allow the UD procedure nurse to have all the information in one place. Your help is crucial to the process. A nurse will review with you prior to your visit.

Medication Questionnaire – Fill out this questionnaire as thoroughly as possible. Attach a separate sheet or write on the back of the form if additional space is needed.

Bladder Diary – While the General Questionnaire is important**, the Bladder Diary** is crucial to current and ongoing treatment options available to you.

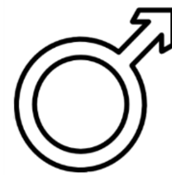
The insurers (your insurance company) often request a copy of **your Bladder Diary** before they will approve any surgical recommendations made by your physician. The bladder diary is a 24-hour record of your intake, output and leakage episodes. It is important to record accurate data during the time period specified by your physician.

For Men who are being tested for possible Sling or Artificial Sphincters.

As mentioned above, you must complete **the General Questionnaire, the Medication Questionnaire and the Bladder Diary.**

For men who are being tested for possible surgeries to include Sling or Artificial Sphincter, a **PAD WEIGHT TEST** must also be completed.

General Questionnaire: Male



DATE: _________________

Patient Name: ___________________________ **Date of Birth:** _____________________

Primary Reason for Visit: ____

Allergies: Latex Y N Iodine: Y N Other: ____________________________

Other urologists you have seen before: ____

Do you have chronic UTIs? Y N **How many per year?** ____________________

Have you ever tried Kegel Exercises or Bio-Feedback? Y N

Ever had bladder instillations? Y N If yes, please describe: _______________________
(i.e. Medications infused into the bladder with a catheter?)

____

Ever received diagnosis related to your urinary problems? Y N If yes, please describe:

____

Please check the appropriate answers during the last month:	**Never**	**One Time**	**Two Times**	**Three Times**	**Four times**	**Five + Times**
How often have you had the sensation of not emptying your bladder completely after you have finished urinating?						
How often have you had to urinate again less than 2 hours after you finished urinating?						
How often have you found you stopped and started again several times when you urinated?						
How often have you found it difficult to postpone urination?						
How often have you had to push or strain to begin urination?						
How many times did you typically get up to urinate from the time you went to bed at night until the time you got up in the morning?						

Male Questionnaire continued

How often do you urinate during your waking hours? ______________________________

Do you wake up to urinate? Y N If yes, how many times per night? _______________

Do you ever wake up wet? Y N If yes, how many times per week? _______________

Are there any activities that make you lose urine? Y N If yes, please list ___________

____

Do you use protection for urinary leakage? Y N **If yes, how many daily:**

Toilet Paper ______ Penile Clamps ______ Panty liners ______

Incontinence briefs ______ Shield-type pads ______

Please indicate the following:

Date(s) of any back surgeries: ____

Date(s) of any car accidents: ____

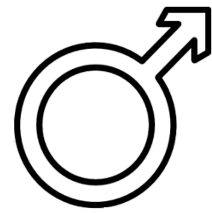
Date(s) of any spinal cord injuries: ____

Date(s) of any hemorrhoid surgeries: ____

Have you ever had a device implanted? Y N **If yes, please list:** __________________
(i.e. Steel rods, IUD, Pacemaker, InterStim, other?)

A nurse will call you prior to your visit to review questions

This Page is for Men Only



Pad Weight Test for Sling or Sphincters

- First weigh one of the pads you use to see what it weighs dry.
- Next collect all of the pads you use in 24 hours and keep them in a ziplock or plastic bag so the urine does not evaporate.
- Next weigh all of the wet pads to see the total weight of pads plus urine.
- Last subtract the dry weight for the number of pads used in 24 hours.
- Keep track of urine loss for 7-10 days to get a good idea of light days and heavy days.

Use the "Pad Weight Chart" below to record the number of pads used during a 24 hour period, including their dry and weight wets. Add additional pages if needed.

An example of how to calculate the Total Urine Loss in 24 Hours:

Dry pad weight (one pad)	2 ounces
Wet pad weight (24hrs)	16 ounces
Number of pads used X dry weight (3 pads X 2 oz)	- 6 ounces
Total Urine loss in 24 hours	10 ounces

Pad Weight Chart

For each day record the number of pads used and the weight of each used pad. Record pad weights during the number of days specified by your physician.

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	*Example*
Dry pad weight = ______ Record # of pads used and weight of each	Dry pad weight = ______ Record # of pads used and weight of each	Dry pad weight = ______ Record # of pads used and weight of each	Dry pad weight = ______ Record # of pads used and weight of each	Dry pad weight = ______ Record # of pads used and weight of each	Dry pad weight = ______ Record # of pads used and weight of each	Dry pad weight = ______ Record # of pads used and weight of each	*Dry pad weight = 2 oz.* *Record # of pads used and weight of each* *Pad #1 – 4 oz.* *Pad # 2 – 3 oz.* *Pad #3 – 4 oz.* *Pad #4 – 3 oz.* *Pad #5 – 5 oz.* *Pad #6 – 4 oz.*
Total Pads Used ________ X weight of dry pad =________ Weight of all wet pads = _________ Weight of all wet pads – total weight of dry pads = Total weight of pads __________	Total Pads Used ________ X weight of dry pad =________ Weight of all wet pads = _________ Weight of all wet pads – total weight of dry pads = Total weight of pads __________	Total Pads Used ________ X weight of dry pad =________ Weight of all wet pads = _________ Weight of all wet pads – total weight of dry pads = Total weight of pads __________	Total Pads Used ________ X weight of dry pad =________ Weight of all wet pads = _________ Weight of all wet pads – total weight of dry pads = Total weight of pads __________	Total Pads Used ________ X weight of dry pad =________ Weight of all wet pads = _________ Weight of all wet pads – total weight of dry pads = Total weight of pads __________	Total Pads Used ________ X weight of dry pad =________ Weight of all wet pads = _________ Weight of all wet pads – total weight of dry pads = Total weight of pads __________	Total Pads Used ________ X weight of dry pad =________ Weight of all wet pads = _________ Weight of all wet pads – total weight of dry pads = Total weight of pads __________	Total Pads Used *6* X weight of dry pad = *12 oz.* Weight of all wet pads = *23 oz.* Weight of all wet pads – total weight of dry pads = Total weight of pads *11 oz.*

Medication Questionnaire

DATE: __________________

Patient Name: _______________________________ Date of Birth: _________________

Medication Allergies: ____

Significant Health Conditions: ____

Primary Care Physician: ______________________Phone Number: __________________

Other Physician: ___________________________Phone Number: __________________

Please check the length of time you have tried any of the medications listed below. Please check if you are still taking or discontinued taking medications.

	1 mo.	2 mo.	4-6 mo.	6-12 mo.	12+ mo.	Still taking	Not working/ did not work	Med worked, quit due to side effects
Amitriptyline								
Detrol								
Ditropan								
Elmeron								
Enablex								
Flomax								
Oxytrol								
Sanctura								
Urecholine								
Uroxatral								
Vesicare								
Toviaz								
Rapaflo								
Myrbetriq								

LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS
(YOU MAY ATTACH A LIST OR WRITE ON THE BACK IF NECESSARY)

Rx Start Date	Medication/ Supplement Name	Dose (mg)	How often?	Prescription? (Y/N)	Prescribing Physician (if applicable)	Rx Stop Date

Bladder Diary – Day #1

Name: ____________________

Date: ______________________

This diary will help you and your health care team understand your bladder function. It is a 24-hour record of your intake and output as well as leakage episodes. The "sample" line below will show you how to use the diary.

SPECIAL INSTRUCTION:
For patients who perform clean intermittent catheterizations, use "**C**" for amount catheterized out, and "**V**" for amount voided.

Time	Drinks		Urine			ACCIDENTS					
						Accidental Leaks How Much? (check one)			Did you feel a strong urge to go?		What were you doing at the time? (sneezing, having sex, lifting, etc.)
	What Kind?	How Much?	How many times did you pee during the hour?	How Much? C	How Much? V	Small	Medium	Large	Circle One		
Sample	*Coffee*	*2 cups*	*2*	*2 oz.*	*2 oz.*	*X*			*Yes* (circled)	*No*	*Running*
6-7 am									Yes	No	
7-8 am									Yes	No	
8-9 am									Yes	No	
9-10 am									Yes	No	
10-11 am									Yes	No	
11-noon									Yes	No	
12-1 pm									Yes	No	
1-2 pm									Yes	No	
2-3 pm									Yes	No	
3-4 pm									Yes	No	
4-5 pm									Yes	No	
5-6 pm									Yes	No	
6-7 pm									Yes	No	
7-8 pm									Yes	No	
8-9 pm									Yes	No	
9-10 pm									Yes	No	
10-11 pm									Yes	No	
11-midnight									Yes	No	
12-1 am									Yes	No	
1-2 am									Yes	No	
2-3 am									Yes	No	
3-4 am									Yes	No	
4-5 am									Yes	No	
5-6 am									Yes	No	

Total Fluids In:

Day #1 _________________

Total Urine Output:

Day #1 _________________

Bladder Diary – Day #2

Name: ____________________

Date: ______________________

This diary will help you and your health care team understand your bladder function. It is a 24-hour record of your intake and output as well as leakage episodes. The "sample" line below will show you how to use the diary.

SPECIAL INSTRUCTION:
For patients who perform clean intermittent catheterizations, use "**C**" for amount catheterized out, and "**V**" for amount voided.

Time	Drinks		Urine			ACCIDENTS					
						Accidental Leaks How Much? (check one)			Did you feel a strong urge to go?		What were you doing at the time? (sneezing, having sex, lifting, etc.)
	What Kind?	How Much?	How many times did you pee during the hour?	How Much?					Circle One		
				C	V	Small	Medium	Large			
Sample	*Coffee*	*2 cups*	*2*	*2 oz.*	*2 oz.*	*X*			*Yes*	*No*	*Running*
6-7 am									Yes	No	
7-8 am									Yes	No	
8-9 am									Yes	No	
9-10 am									Yes	No	
10-11 am									Yes	No	
11-noon									Yes	No	
12-1 pm									Yes	No	
1-2 pm									Yes	No	
2-3 pm									Yes	No	
3-4 pm									Yes	No	
4-5 pm									Yes	No	
5-6 pm									Yes	No	
6-7 pm									Yes	No	
7-8 pm									Yes	No	
8-9 pm									Yes	No	
9-10 pm									Yes	No	
10-11 pm									Yes	No	
11-midnight									Yes	No	
12-1 am									Yes	No	
1-2 am									Yes	No	
2-3 am									Yes	No	
3-4 am									Yes	No	
4-5 am									Yes	No	
5-6 am									Yes	No	

Total Fluids In:

Day #2 _________________

Total Urine Output:

Day #2 _________________

Bladder Diary – Day #3

Name: ____________________

Date: _____________________

This diary will help you and your health care team understand your bladder function. It is a 24-hour record of your intake and output as well as leakage episodes. The "sample" line below will show you how to use the diary.

SPECIAL INSTRUCTION:
For patients who perform clean intermittent catheterizations, use "**C**" for amount catheterized out, and "**V**" for amount voided.

Time	Drinks		Urine			ACCIDENTS					
						Accidental Leaks How Much? (check one)			Did you feel a strong urge to go?		What were you doing at the time? (sneezing, having sex, lifting, etc.)
	What Kind?	How Much?	How many times did you pee during the hour?	How Much? C	How Much? V	Small	Medium	Large	Circle One		
Sample	*Coffee*	*2 cups*	*2*	*2 oz.*	*2 oz.*	*X*			*Yes* (circled)	*No*	*Running*
6-7 am									Yes	No	
7-8 am									Yes	No	
8-9 am									Yes	No	
9-10 am									Yes	No	
10-11 am									Yes	No	
11-noon									Yes	No	
12-1 pm									Yes	No	
1-2 pm									Yes	No	
2-3 pm									Yes	No	
3-4 pm									Yes	No	
4-5 pm									Yes	No	
5-6 pm									Yes	No	
6-7 pm									Yes	No	
7-8 pm									Yes	No	
8-9 pm									Yes	No	
9-10 pm									Yes	No	
10-11 pm									Yes	No	
11-midnight									Yes	No	
12-1 am									Yes	No	
1-2 am									Yes	No	
2-3 am									Yes	No	
3-4 am									Yes	No	
4-5 am									Yes	No	
5-6 am									Yes	No	

Total Fluids In:

Day #3 _________________

Total Urine Output:

Day #3 _________________