METROVAN UROLOGY
metrovanurology.com
#650 – 6091 Gilbert Road
Richmond, B.C. V7C 5L9
Tel: **604 273 4320**
Fax: 604 273 7599

Previsit Questionnaire

PLEASE PRINT ONLY

Patient's Legal Name: _____
LAST NAME (LEGAL) GIVEN NAMES (LEGAL) PREVIOUS SURNAME(S)

Personal Health Care Number: _____ **Sex:** ☐ Male ☐ Female

Birthdate: Day _____ Month _____Year _____ Marital Status: _____

Your Present Address: _____

City: _____ Province: _____ Postal Code: _____

Which Month & Year Did You Move to the Above Address? _____

Previous Address (if less than 12 months at present address): _____

City: _____ Province: _____ Postal Code: _____

Which Month & Year Did You Move to This Address? _____

Present Employer: _____ Occupation _____

Since: Month _____ Year _____

Next of Kin: Name _____ Relationship _____
LAST NAME GIVEN NAME

Telephone: Please check the best number to contact you at.

(Home) ☐ _____ (Work) ☐ _____

(Cell) ☐ _____ (Other) ☐ _____

Is it OK to contact you on your cell phone? ☐ Yes ☐ No

Is it OK to contact you by email? ☐ Yes ☐ No

(Email): _____

USE OF EMAIL IS RESTRICTED TO SCHEDULING APPOINTMENTS. Please note that no confidential information such as results will be sent by email. We will NOT respond to email with medical questions.

This section only applicable if you are admitted for surgery

Accommodation Preferred (subject to availability only): ☐ Private Room ☐ Semi-Private Room ☐ Standard Ward

There is a Charge for Semi & Private Rooms – Payable on Discharge

Have You Ever Been a Patient in The Richmond Hospital: ☐ No ☐ Yes – when? _____

Urologist: _____ Family Physician: _____

Were You Born in B.C.? ☐ Yes ☐ No **If not, date of arrival in B.C.:** _____

Canadian Citizen? _____ **Landed Immigrant?** _____ **If Landed Immigrant and Have Lived in Canada Less than 1 Year, Photocopy of Immigration Papers Must be Provided Upon Admission.**

Thank you for completing this questionnaire. Email, Print, Fax or Bring to your appointment.

Richmond Hospital
part of the Vancouver Coastal Health Authority

PCIS LABEL

Surgeon:_____

Patient Name:_____ Sex:_____ Date of Birth:_____

Weight:_____lbs./kgs. Height:_____in./cm.

Check [✓] the correct column after each question. PLEASE COMPLETE BOTH SIDES OF THE PAGE.

	Yes	No	Not sure		Yes	No	Not sure
Do you currently have or do you have a history of:				Do you currently have or do you have a history of:			
1. Heart pain / angina				22. Kidney problems / failure			
2. Heart attack				23. Heartburn / hiatus hernia			
3. Heart murmur / heart valve problem				24. Liver disease / jaundice / hepatitis			
4. Stroke				25. Thyroid problems			
5. High blood pressure				26. Arthritis			
6. Irregular pulse				27. Bleeding disorders - yourself			
7. Circulation problems				- other family members			
8. Asthma / bronchitis / emphysema				28. Paralysis / weakness			
9. Shortness of breath with daily activity				29. Numbness of face or limbs			
10. New cough or cold				30. Seizures			
11. Chronic cough				31. Tumors / malignancy			
12. Sleep apnea or use a CPAP machine				32. Previous blood transfusion reactions			
Do you take:				33. Diabetes			
13. Pills for high blood pressure				- If **YES**, circle your treatment: diet only; insulin; pills			
14. Pills to thin your blood				34. Are you, or could you be, pregnant?			
15. Antibiotics before dental work				35. Do you have any other medical problems?			
16. Cortisone-like pills within last 6 months				Do you have:			
Do you:				Dentures	Upper		Lower
17. Smoke tobacco? How much?				Partial plate / dentures	Upper		Lower
18. Have you quit? When?				Capped / loose teeth			
19. Drink alcohol regularly? How much?				Hearing difficulties			
20. Take street drugs? What?				Hearing aid	Right		Left
21. Have you or any member of your family had any problems with anesthetics?				Glasses / contact lens / lens implant / prosthetic eye	Right		Left
Indicate who:							

If **YES** to any of the above questions, please explain: _____

_____

_____

_____

_____

Please turn over and complete Page 2 ➡

Do you have any allergies? Yes ☐ No ☐

Allergy to	Allergic Reaction

Please list all the medications and herbal supplements you take (use a separate piece of paper if you need more space):

Medication / Supplement Name	Dose (amount taken each time)	How often do you take it?	Reason for taking

List any operations you have had:

Date: Operation:

Is there anything else you want us to know about you?

Completed by (please print name): _____ **Date:** _____

If you are not the patient, what is your relationship to the patient? _____

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Urinary History - Female

PURPOSE: This will assist your Urologist in helping to manage your problem. It is used to supplement the traditional medical evaluation. All information is strictly confidential.

Mark [X or ✓] in the correct column after each question. If YES to any of the below questions, please explain.

	Yes	No	Not Sure		Yes	No	Not Sure
PART 1: PREGNANCIES Skip if you have never been pregnant				**PART 4: URINARY SYMPTOMS**			
1. Number of times pregnant				30. Slow urinary stream			
2. Number of children				31. Straining/pushing to urinate			
3. Vaginal (natural) delivery				32. Sensation that the bladder does not empty			
4. C-section (Cesarian)				33. Waking at night to urinate more than twice			
5. Episiotomy (cut to widen the vagina)				34. Difficulty postponing urination			
PART 2: GYNECOLOGICAL HISTORY				35. Constipation			
6. Endometriosis				36. Sensation of pelvic pressure			
7. Uterine fibroids				37. Sensation that something is 'falling down' in the vagina			
8. Pelvic prolapse (cystocele, rectocele)				38. Urinary incontinence (leakage)			
9. Pelvic radiation				IF YOU DO NOT HAVE URINARY LEAKAGE YOU CAN SKIP THE NEXT SECTION			
10. Cancer of the cervix				**PART 5: URINARY INCONTINENCE**			
11. Cancer of the uterus				39. When did you first notice the leakage?			
12. Cancer of the breast				40. Do you need to wear protective pads?			
13. Pain with intercourse				41. How many pads per day do you use?			
14. Vaginal dryness				42. Is the leakage getting worse?			
15. Hysterectomy (removal of uterus/womb)				43. How often to you usually urinate in a day?			
16. Oophorectomy (removal of ovary)				44. Do you have difficulty delaying urination?			
17. Surgery for urinary leakage/incontinence				45. Have you needed to adjust your activities because of urinary leakage?			
18. Surgery for pelvic prolapse				**Leakage is occurring with:**			
19. Oral contraceptives				46. Coughing			
20. Systemic estrogen replacement				47. Laughing			
21. Vaginal estrogen replacement				48. Standing			
PART 3: UROLOGY HISTORY				49. Intercourse			
22. Blood in the urine (hematuria)				50. Exercise - minimal			
23. Bladder infection				51. Exercise - vigorous			
24. Kidney infection				52. Doing nothing			
25. Chlamydia				53. At night			
26. Gonorrhea				**Have you tried any of the following?**			
27. Herpes				54. Kegel exercises			
28. Kidney stones				55. Reduction in fluid or caffeine intake			
29. Neurological problem (e.g. MS, stroke, spinal cord problem)				56. Medications to relax the bladder*			

* Bladder relaxant medications: Ditropan (oxybutynin), Uromax, Detrol (tolterodine), Enablex (Darifenacin), Vesicare (solifenacin)

If YES to any of the above questions, please explain if necessary: _____

_____

_____

_____

_____

PLEASE COMPLETE ALL PAGES

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Voiding Diary

Last Name (REQUIRED) First Name (REQUIRED) PHN/CARE CARD NUMBER (REQUIRED)

Instructions: Print out this sheet and fill in the table.

1. Please use a **measuring cup** (e.g. for cooking) to report the volume of urine you pass each time you go to the washroom. We prefer that you record the volume in milliliters (ml) or cubic centiliters (cc), but ounces are fine.
2. **3 Days & Nights** is ideal. The days **do not** need to be in a row. Start recording from the time you wake up for a 24 hour cycle.
3. Do not change your drinking habits for the test.
4. Please make a note of any episodes of incontinence (urine loss)

e.g.

Time	Amount Voided	Leak
9 am	250 cc	No
1030 am	200 cc	No

Notes: 1 ounce (Oz) = 30 cc (ml)
PLEASE BRING TO YOUR NEXT APPOINTMENT OR CYSTOSCOPY

DAY 1 Date:

Time	Amount Voided	Leak? Yes/No

DAY 2 Date:

Time	Amount Voided	Leak? Yes/No

DAY 3 Date:

Time	Amount Voided	Leak? Yes/No