UROLOGY ASSOCIATES of Green Bay

MALE UROLOGY INTAKE FORM

Patient Name: ____ DOB: ________________

Date of Visit: ___/___/___ **Primary Care Physician**: _____________________________

Determine your BPH symptoms Circle your answers and add up your scores at the bottom

Over the past month:	**Not at All**	**Less than one time in five**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
Incomplete emptying- How often have you had the sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Frequency- How often have you had to urinate again less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Intermittency- How often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
Urgency- How often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
Weak Stream- How often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
Straining- How often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**
Sleeping- 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?	None **0**	One Time **1**	Two Times **2**	Three Times **3**	Four Times **4**	Five + Times **5**
Add Symptom Scores						

Total International Prostate Symptom Score (IPSS) = ________

QUALITY OF LIFE	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

1/30/2026 Approved By:

Sexual Health Inventory for Men (SHIM) - Rate symptoms on a scale of 0-5, circle answers and add up your score at the bottom

Over the past 6 months:	Not sexually active	Very Low	Low	Moderate	High	Very High
How do you rate your confidence that you could get and keep an erection?	0	1	2	3	4	5
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	0	1	2	3	4	5
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	0	1	2	3	4	5
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	0	1	2	3	4	5
When you attempted sexual intercourse, how often was it satisfactory for you?	0	1	2	3	4	5

Total SHIM Score = __________

Hormone & Vitality Screening

In the past 6-12 months, have you experienced any of the following?

- ☐ Reduced energy or increased fatigue
- ☐ Decreased interest in sexual activity (low libido)
- ☐ Changes in erections or erectile quality
- ☐ Lump or curve in your erection
- ☐ Depressed mood, irritability, or low motivation
- ☐ Difficulty concentrating or mental "fog"
- ☐ Decreased muscle strength or increased body fat

Testosterone History

Have you ever had your testosterone level checked? Yes or No
Have you previously used testosterone therapy (injections, gels, pellets, etc)? Yes or No
Would you like to discuss testosterone testing or hormone evaluation further? Yes or No