Patient Registration Form

Last Name: _____ First name: _____ MI: ____ Today's Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Home #: (_____) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

DOB: ____/_____/_____ AGE: _____ Height: _____ Weight: _____

SS# _____-_____-_____ Married/Single/Divorced/Widowed

Employer: _____ Occupation: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact #: _____

Primary Insurance: _____ Secondary Insurance: _____

ID: _____ Group#: _____ ID#: _____ Group#: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's DOB: _____

Preferred Pharmacy:

Name: _____

Address: _____

Phone/Fax Number: _____

How did you hear about us?

___ Walk-in ____Family/Friend ____Brochure ____Internet ___Television ____Radio

Reason for visit: _____

Symptoms Began: _____ Years _____ Months _____

Have you ever used anabolic steroids or boosters? ____ Yes ____ No

Overall Symptom Severity ____ Mild ____ Moderate ____ Severe

Fatigue? ____ Mild ____ Moderate ____ Severe

Lack of Energy ____ Mild ____ Moderate _____ Severe

Decreased Libido/Sex Drive? ____ Mild ____ Moderate ____ Severe

Erectile Dysfunction? ____ Mild ____ Moderate ____ Severe

Morning Erection: ____ None _____ Rarely _____ Normal

Mental Fatigue/Decrease Memory/Intellectual Performance: ___ Slight ___Moderate ___Severe

Unexplained Weight Gain? ____ Mild ____ Moderate _____ Severe If so, how much _____

Sadness/Depression/Moodiness? ____ Mild ____ Moderate ____ Severe

Decreased Muscle Size or Strength _____ Slight _____ Moderate _____ Severe

Decrease in Physical Activity: ____ Slight _____ Moderate _____ Severe

Sleep Trouble? ____ Yes ____ No Have you been diagnosed with Sleep Apnea? ____ Yes ____ No

Falling Asleep? ____ Yes _____ No Staying Asleep? ____ Yes ____ No

Check if you have: ___ Nipple tingling/tenderness ___ Breast tissue ___ Hand/Foot swelling

Medical History-Self and/or Family

Sleep Apnea/Snoring	____ Self ___Family	Kidney Disease	____Self ___ Family
Anxiety Depression	____ Self ___Family	Obesity	____Self ___ Family
Liver Disease	____Self ___ Family	Heart Disease/Stroke	____Self ___ Family
Hypertension	____Self ___ Family	High Cholesterol	____Self ___ Family
Infertility	____Self ___ Family	HIV Positive	____Self ___ Family
Anemia	____Self ___ Family	Blood Disorder	____Self ___ Family
Diabetes Type 1 or 2	____Self ___ Family	Hemochromatosis	____Self ___ Family
Thyroid Cancer	____Self ___ Family	Prostate Cancer	____Self ___ Family
Thyroid Enlargement	____Self ___ Family	Prostate Enlargement	____Self ___ Family
Hypothyroidism	____Self ___ Family	Breast Cancer	____Self ___ Family
Hypogonadism	____Self ___ Family		
Peripheral Arterial Disease	____Self ___ Family		
Reproductive/Fertility Disorder	____Self ___ Family		
Chronic Lymph Node Enlargement	____Self ___ Family		
Prior Testosterone replacement/exposure	____Self ___ Family		

List all medications you are currently taking: _____
_____

Are you allergic to any medications, foods, or vegetable/seed oils? ___ Yes ___ No
List them: _____

Other Past Medical History/Current Medical Issues/Past Surgeries _____
_____

Other Family Medical History: _____
_____

Have you had a comprehensive physical exam in the last 12 months? _____ Yes _____ No

If 40 years old or older, have you had a prostate exam in the last 12 months? ____ Yes ____ No

Date of last DRE (Digital Rectal Exam) _____ (month/year) DRE RESULTS ____ Normal ____ Abnormal

Tobacco Use: Chew ____ Smoke ____ Vape ____

How much a day? _____ How long? _____

Smoking Tobacco Use: ____ None ____ Occasional ____ Frequent _____ Daily

Opioid or Pain Medication Use: ____ None ____ Occasional ____ Frequent _____ Daily

Alcohol Use: ____ Yes ____ No How many drinks per week? _____

Recreational Drug Use: ____ None ____ Occasional ____ Frequent _____ Daily

Caffeine Use: ____ None ____ Occasional ____ Frequent _____ Daily

Coffee ___ Tea___ Energy Drinks____ Oher: _____

Do you have children? ____ Yes ____ No Do you want more children? ____ Yes____ No

What is your exercise level? ____ Sedentary _____ Occasional _____ Regular

Symptom Review:

___ Decreased Appetite
___ Night Sweats
___ Blurry/Double Vision
___ Visual Disturbances
___ Hearing Loss
___ Ringing in the Ears
___ Altered Sense of Smell
___ Acne
___ Rash
___ Shortness of Breath
___ Persistent Nonproductive Cough
___ Wheezing
___ Chest Pain/Pressure
___ Fainting Spells
___ Palpitations
___ Swallowing Difficulties
___ Heart Burn
___ Persistent Nausea
___ Vomiting
___ Abdominal Pain
___ Urinary Frequency
___ Frequent Urination at Nighttime
___ Urinary Urgency
___ Urinary Hesitation
___ Dribbling after Urination
___ Painful Urination
___ Blood in Urine
___ Dizziness
___ Frequent Headaches
___ Single Extremity Weakness
___ Intolerance Hot/Cold
___ Chronic Pain
___ Joint Pain
___ Excessive Thirst
___ Appetite Problem
___ Irritability
___ Suicidal Thoughts
___ Low Self-Esteem
___ Insomnia

Patient Signature: _____ **Date:** _____

General Consent for Medical Treatment/Healthcare

POLICIES AND PROCEDURES:

We will collect your deductible, co-insurance, co-payment and/or non-covered charges at the time of visit. Please be advised that this is NOT a guarantee of benefits. The amount collected at the time of service is based on a verification of benefits and is subject to change after the claim has been submitted and processed.

- Insurance Denial: If your insurance company denies your charges, you will be expected to pay balance within 30 days or call our billing department for payment arrangements.
- Managed Care: (HMO, PPO): Your co-pay or deductible will be collected at time of service.
- Self –Pay Patients: Patients without medical coverage are expected to pay at time of service.

If you have any questions regarding our financial policy, please contact our billing department at 281-854-6294/713-482-2186. _____ (Initial)

CONSENT TO OBTAIN PATIENT HISTORY: I understand that Titan shall maintain documentation of the medical care received. This medical record will typically include symptoms, health conditions, results of physical exam and diagnostic tests, medications, a treatment plan; as well as demographic and photographic identifiers. Such information is protected health information (PHI) and can be used, shared or disclosed only for the purpose of treatment, payment, and healthcare procedures. _____ (Initial)

HIPPA/ NOTICE OF PRIVACY PRACTICE: I understand that the patient's health information is private and confidential. I understand that Titan may disclose PHI to provide care to the patient and handle billing & payment. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communications or alternative locations. I authorize Titan to use and/ or disclose my PHI. _____ (Initial)

AUTHORIZATION TO USE OR DISCLOSE MEDICAL INFORMATION: I authorize Titan the use or disclosure of my individually identifiable health information as described: complete health record, progress notes, laboratory tests. This information is to be disclosed to: Titan T-Center & Weight Loss _____ (Initial)

CONSENT FOR TREATMENT: I hereby voluntarily consent to care, testing, treatment and any services performed by healthcare providers at Titan. I understand that I have the right to refuse any proposed care, testing or procedures. I have the right to ask questions and discuss concerns with my healthcare team. _____ (Initial)

ADVANCE DIRECTIVES: Adults 18 and older have the right to designate a patient representative to make medical decisions if they lose individual decision-making capacity. I understand that this is available to me if needed. _____ (Initial)

LABS: I authorize Titan to run labs ordered by the practitioners. I understand I may receive an explanation of benefits from insurance company. This is a statement sent via your health insurance company explaining what was paid on their behalf. _____ (Initial)

MODEL RELEASE: I give Titan rights to use my "Before & After" photos for advertising purposes. I hereby release and agree to hold Titan and their legal representatives harmless from any liability by any contents used. Circle **YES** or **NO** _____ (Initial)

PREGNANCY: I understand that being pregnant is a contraindication to certain services at Titan. Should I be pregnant, there is risk to my unborn child. I can deny pregnancy testing at any time. I release liability to the healthcare team based on this decision. _____ (Initial)

PATIENT RIGHTS & RESPONSIBILITY: I acknowledge that my healthcare is a partnership between Titan and me. I understand that my provider will verbally inform me of side effects, allergic responses and potential complications that may occur. I have the right to request educational handouts regarding care. I agree to actively participate and accept responsibility to my healthcare. I understand that much of the success of the program will depend on my efforts. _____ (Initial)

Patient Signature _____ Date: _____

Policies and Procedures

Titan T-Center and Weight Loss will collect your deductible, co-insurance, co-payment and/or any non-covered charges at the time of your visit. Please be advised that this is NOT a guarantee of benefits. The amount collected at the time of service is based on a verification of benefits and is subject to change after the claim has been submitted and processed by your insurance company. After the explanation of Benefits (EOB) is received from your insurance company, the proper adjustments and/or payments will be made and at that time will be billed or refunded any money due to you.

Insurance Denial: If your insurance company denies our charges, or does not pay us in a timely manner, you will be billed for the entire balance. You will be expected to pay your balance in full within 30 days or call our billing department to make payment arrangements. If payment is not received in a timely manner, your account may be subject to more aggressive collection methods.

Managed Care (HMO, PPO) Patients: If we participate with your plan, we will bill your insurance for you, however, your co-pay, deductible, or co-insurance will be collected at the time of service, no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has your physician on file, and it is your responsibility to obtain a referral from your PCP prior to your visit with us. If we do not have a valid referral at the time of service, you will be responsible for payment that day.

Self-Pay Patients: Patients without medical coverage will be expected to pay at the time of service. If you are unable to make a payment in full, you must make a payment agreement at the time of service.

Remember whether you do or do not have medical insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (832) 738-1913.

By signing the consent document, I acknowledge I have read, understand, and will adhere to Titan T-Center and Weight Loss policies and procedures.

Patient Signature _____ **Date** _____

Policías y Procedimientos

Titan T-Center & Weight Loss recogerán su, coaseguro, copago deducible y / o cargos no cubiertos en el momento de su visita. Por favor, tenga en cuenta que esto no es una garantía de beneficios. El monto recaudado en el momento del servicio se basa en la verificación de beneficios y está sujeta a cambios después de la reclamación ha sido presentada y procesada por su compañía de seguros. Después de recibir la explicación de beneficios (EOB) de su compañía de seguros, se harán los ajustes y / o pagos apropiados y en ese momento se facturará o reembolsará ningún dinero

Seguros Negación: Si su compañía de seguros niega nuestros cargos, o no nos pagan en el momento oportuno, se le facturará por la totalidad del saldo. Se espera que pagar el saldo completo dentro de los 30 días o llame a nuestro departamento de facturación para hacer arreglos de pago. Si el pago no se recibe en el momento oportuno, su cuenta puede estar sujeta a los métodos de recolección más agresivos.

Managed Care (HMO, PPO) Pacientes: Si participamos con su plan, le cuenta a su seguro para usted, sin embargo, su copago, deducible o coaseguro se aplica en el momento del servicio, sin excepciones. Si su plan requiere que usted elija un médico de atención primaria, es su responsabilidad asegurarse de que su compañía de seguros tiene su médico en el archivo, y es su responsabilidad de obtener una referencia de su PCP antes de su visita con nosotros. Si no tenemos una referencia válida en el momento del servicio, usted será responsable del pago de ese

Auto-pago Pacientes: Los pacientes sin cobertura médica se espera que pague en el momento del servicio. Si usted no puede hacer un pago en su totalidad, usted debe hacer un acuerdo de pago en el momento del servicio.

Recuerde si hacer o no tiene seguro médico, usted es en última instancia responsable económicamente por el pago de sus cargos. Si usted tiene alguna pregunta acerca de nuestra política financiera, por favor póngase en contacto con nuestro departamento de facturación al (832) 738-1913.

Al firmar el documento de consentimiento, reconozco que he leído, entiendo, y voy a adherir a la Titan T-Center and Weight Loss.

Patinete Signatura _____ **Fecha** _____

Hormone and Health

It is important to Titan T-Center and Weight Loss Clinic that you understand the risks and benefits associated with Testosterone Replacement Therapy before beginning or continuing treatment. TRT is not a new area of medicine and is used for the treatment of a medical condition known as hypogonadism in males. You should also be aware of alternatives to TRT, including not receiving TRT treatment. It is important that you consider the information provided and discussed the information carefully with your provider. Be sure that you are doing what is right for you. If you are unsure, then you should refuse and/or discontinue treatment.

The hormones that may be prescribed as part of your treatment may include Progesterone, and Testosterone as well Vitamin D, B12, and other dietary supplements, where indicated. Recommended treatment in some instances may include "off label" drug use of an approved FDA medication, such as progesterone in men. Testosterone is FDA-Approved only for use in men who lack or have low testosterone levels in conjunction with associated symptoms. These symptoms are often related to male andropause, or aging, and may include decreases in energy and motivation, poor concentration or memory, feelings of depression or irritability, sleep disturbances, reduced muscle mass, increased body fat, and reduced sexual desire or libido. These symptoms may be treatable in hypogonadal males utilizing testosterone. The therapeutic objective of TRT is to restore normal testosterone levels helping to reduce these symptoms. There are several potential side effects related to TRT. You should discuss each off these with your medical provider. Side effects may include increased red blood cells, acne, sleep apnea, breast enlargement, testicular atrophy, lowered sperm count, mood swings, injection site reactions such as bleeding, pain, swelling, redness, or infection, increased estrogen production, or fluid retention. TRT is not recommended for patients who have breast or prostate cancer, or who are thinking about becoming parents. You should also be aware that some recent studies have associated TRT with increased risk for adverse cardiovascular events, such as blood clots, heart attacks, or strokes, in certain types of patients. If you have a history of cardiac or urologic problems, your provider may require clearance from your cardiologist or urologist prior to initiation treatment. Each patient's own risks can vary depending upon health history and lifestyle. It is important that you provider an accurate and complete medical history to your provider.

Please tell your provider if you have used alcohol or illicit drugs prior to treatment visit. You and your health care provider need to discuss the risks and benefits of treatment before you start or continue treatment.

Patient:

This is my consent for Titan T-Center and Weight Loss, including any physician, mid-level provider or nurse who works with Titan T-Center and Weight Loss, to begin treatment for Hormone Replacement Therapy.

I have read and understand that there may be complications arising from or related to treatment as described above and have been explained. I have had an opportunity to discuss my complete past medical and health history including any serious problems and/or injuries, as well as my family history of disease and conditions, with my provider. All my questions concerning the risks, benefits, and alternatives to treatment have been answered. I am satisfied with the answers and desire to commence treatment, knowing the risks and potential side effects involved.

- I understand that I will have periodic blood test to monitor my blood levels of testosterone and I consent to such testing. I understand that the physical exam by my Titan provider does NOT replace a full physical exam by my personal physician, and I agree to have my person physician {not Titan T-Center and Weight Loss} perform a full physical exam including a lipid profile, cholesterol profile, digital rectal exam, and full metabolic panel, not less than annually.
- I understand that each patient is different and there are no guarantees as to results obtainable from TRT treatment. TT is not a cure, and if I stop treatment, symptoms may return or worsen.
- I am not currently attempting to father children. If this changes, I will advise my provider at Titan immediately.
- I do not have and have not been diagnosed with cancer.

Consent to have Blood Drawn for Treatment/Testing

I authorize the medical staff at Titan to obtain a blood sample for the purpose of determining specific laboratory test levels.

Consent to obtain Prescription History

I authorize the Titan T-Center and Weight Loss clinic to obtain my prescription history from the E-prescribing network system. This information will only be used by the providers of the Titan T-Center and Weight Loss clinic for the sole purpose of keeping a current and accurate listing of medications.

Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in Titan T-Center and Weight Loss treatment program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics of these receipts and limitations as described in the document. I accept these specific policy rules.

Patient Signature: _____ Date: _____

Weight Loss Specific Questions:

What program are you looking at doing today?

- **Growth Hormone Peptides:** is a compound that stimulates the pituitary gland to produce growth hormones. At night, during your body's natural cycle of growth hormone production, Sermorelin stimulates the pituitary gland during REM sleep. The pituitary gland produces growth hormones which repair tissue, bones, nerves, and more. GHRP2 also acts as an appetite suppressant allowing for increased weight loss.
- **HCG 23:** is a subcutaneous injection that has been safely used to enhance and accelerate weight loss for over 60 years. This hormone allows the body to mobilize fat and use it as energy. Research suggests given in low doses weight loss of a ½ pound per day when accompanied by a low caloric intake. It is given upon awakening once a day for 23 - 45 days, depending on the individual's medical history and weight management goals.
- **Phentermine:** is a medication for chronic weight management. It is for people with overweight and weight-related complications or obesity. It is meant to be used together with a lifestyle therapy regimen involving a reduced calorie diet and increased physical activity. Generally, a patient needs to have a BMI >25.

Human Growth Hormone Peptide

Risks vs Benefits of HGH Peptide Therapy and understand that this treatment is elective. I have been made aware that the following are possible adverse events/reactions:

- I understand that therapy may awaken laten cancers, may promote metabolic disorders such as diabetes and may exacerbate the decline of other endocrine functions by changing and/or distorting essential hormonal interactions.
- I understand that HCH benefits may take 4-8 weeks to take effect. If no positive effects are noted at this point, I will have serial blood draws to measure effectiveness prior to continuing treatment.
- I understand how to draw and administer HGH peptide and agree to take the exact dose prescribed by my provider.
- I understand the other side effects include: Injection site reactions (such as pain, swelling, or redness), headache, flushing, difficulty swallowing, dizziness, hyperactivity, sleepiness, hives, nausea, vomiting, change in taste, pale skin, or tightness in chest. If any of these reactions occur, medication should be discounted immediately, and I will seek appropriate medical attention.

Patient Informed Consent for Medical Weight Loss with use of Phentermine

I hereby authorize Titan T- Center & Weight Loss to assist me in my weight reduction efforts. I understand that my treatment program consists of a balance diet, a regular exercise program, instruction in behavior modification techniques, meeting with a registered dietician, and the use of appetite suppressant medication Phentermine. I also understand that regular medical visits will be necessary while on the medication and that Phentermine must be used with caution and under direct supervision of Titan T – Center & Weight Loss.

Risk of Proposed Treatment: I understand that any medical treatment may involve risks as well as proposed benefits of weight loss. I understand that this authorization is given with the knowledge that the use of Phentermine involves risks. Risks of Phentermine include but are not limited to nervousness, diarrhea, constipation, sleeplessness, headache, tremor, fever, fainting, dry mouth, rash, change in libido, difficulty urinating, shortness of breath, swelling of feet or ankles, tiredness, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, hallucination, stomach cramps, high blood pressure, palpitation, arrhythmias, rapid heart rate, and gall stones. Although seen only in rare cases, pulmonary hypertension, or heart valve disease may develop. These latter two conditions are serious and can be fatal. In case of serious side effects, stop taking the Phentermine and see immediate medical assistance. In Addition, Phentermine can be addictive and should not be used with a history of drug dependence. I also

understand that there are certain health risks associated with remaining overweight or obese including high blood pressure, diabetes, heart attack, heart disease, arthritis of the joints, sleep apnea, and sudden death.

I further understand that phentermine should not be used by people who suffer from heart disease, glaucoma, history of a stroke, liver or kidney disease, those with history of drug dependency, alcoholism, psychotic illness, uncontrolled hypertension, advanced atherosclerosis, thyroid over-activity, people are on MAOI's, serotonin migraine medications, or lithium.

While taking Phentermine avoid taking the following medication:

Decongestant medication, {Sudafed/pseudoephedrine, Tylenol sinus, Claritin D, Zyrtec D, Allegra D}, stimulate medications, high doses of caffeine, other weight loss medication, ephedrine MAO inhibitions and alcohol.

Patient Responsibility: As the patient, I understand it is my responsibility to follow instructions carefully, and to report to Titan T-Center & Weight Loss any significant medical problems that I think may be related to my weight control program as soon as possible. I agree to notify Titan T – Center & Weight Loss of any medical problems that I may have, or any results of labs/tests ordered and reviewed by any other physician. I further acknowledge that I enter this program in full knowledge and understanding that no physician, provider, or staff of the weight loss physician has prior knowledge as to whether I would or would not have adverse effect since each individual has a different biological and chemical make-up. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight reduction and weight maintenance. I understand that a balanced caloric counting program combined with regular exercise without the use of Phentermine may likely prove successful if followed, even thought I would be hungrier than without the suppressant.

Phentermine may result in lethargy or depression with abrupt discontinuation, and I understand that during the program, medications will be discontinued if:

- I become pregnant, try to become pregnant, or suspect that I am pregnant.
- I develop a contraindication or serious side effect of the medication.
- I do not comply with medical requirements, i.e., visits, med doses, etc.
- I fail to lose and/or maintain weight appropriately.
- I have a planned surgery. Medications are to be stopped at least 2 weeks prior to any surgical procedure requiring general anesthesia.

Woman Only: I understand Phentermine should not be taken during pregnancy, due to the change of damage to the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both Titan T-Center & Weight Loss and my OB/GYN immediately. In addition, Phentermine is not to be used while breast feeding.

NO GAURANTEE: I UNDERSTAND THAT MUCH OF THE SUCCESS OF THE PROGRAM WILL DEPEND ON MY EFFORT, AND THAT THERE IS NO GUARANTEE THAT THE PROGRAM WILL BE SUCESSFUL. I UNDERSTAND THAT I WILL HAVE TO CONTINUE WITH SENSIBLE AND NUTRITIONAL EATING HABITS AND REGULAR EXERCISE ALL OF MY LIFE, IF I AM TO BE SUCESSFUL LONG TERM.

Patient Consent/Waiver: I have read and fully understand this document and authorize and accept the proposed care regardless of the risks. I affirm that my questions have been satisfactorily answered at this time. I realize that I should not sign this form if all items are not understood by me or if my questions have not been answered to my satisfaction. I hereby release Titan T-Center & Weight loss from any liability associated and connected with my participation in this weight loss program. I accept the risks as discussed above, in hopes of obtaining desired beneficial results of weight loss treatment.

WARNING: If you have any questions as to the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask the physician of Titan T-Center & Weight Loss now before signing this consent form. To conclude, by signing this document you are agreeing to the risks associated with Phentermine, and any of the weight loss programs offered by Titan T-Center & Weight Loss. You are agreeing that to be successful in your weight loss goals you must alter your lifestyle and adapt healthy eating and exercise patterns. You are agreeing that you are not pregnant or breast feeding. You are agreeing that you understand Phentermine may be addictive. You are agreeing that you must notify Titan T-Center and Weight Loss of any medical conditions current or that develop while taking any of the medications prescribed and you are agreeing that this document has been adequately explained to you and that you understand the documents in its entirety.

Patient Name: _____

Patient Signature: _____ Date**:** _____

TITAN
T-CENTER & WEIGHT LOSS

AUA SYMPTOM SCORE (AUASS) AND QUALITY OF LIFE (QOL)

PATIENT NAME:_____ **DATE:**_____

(Circle One Number On Each Line)	Not at All	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urination?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
Over the past month, how many times per night 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?	0	1	2	3	4	5

Add the score for each item above and write the TOTAL here: _____

SYMPTOM SCORE: **1-7 (Mild** **8-19 (Moderate)** **20-35 (Severe)**

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6