Dr. E. Padayachee Inc. Specialist Urologist

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COMPREHENSIVE UROLOGY ASSESSMENT PACK

PAGE 1 — PATIENT DETAILS&PRESENTING SYMPTOMS

Patient Information

Patient name: _____ Date: _____
Date of birth: _____ ID/Passport no.: _____
Contact number: _____ Email: _____
Address: _____
Medical aid: _____ Membership no.: _____
Referring doctor: _____ Practice/contact: _____
Preferred language: _____ Emergency contact: _____

Reason for Visit / Main Concern

Main problem or reason for referral: _____
_____
When did this problem start? _____ Is it: ☐ New ☐ Recurrent ☐ Ongoing

Urinary Symptoms

☐ Frequency ☐ Urgency ☐ Nocturia ☐ Burning/pain passing urine ☐ Weak stream
☐ Hesitancy ☐ Intermittent stream ☐ Straining ☐ Incomplete emptying
☐ Dribbling ☐ Difficulty starting ☐ Urinary retention ☐ Reduced urine output
☐ Increased urine volume ☐ Other: _____
Typical daytime frequency: _____ times/day Night-time urination: _____ times/night
Urine leakage: ☐ No ☐ Yes — frequency: _____ Triggers: _____

Haematuria / Blood in Urine

☐ No ☐ Yes — visible ☐ Microscopic / detected on testing
First noticed: _____ Episodes: _____
☐ Clots ☐ Pain with bleeding ☐ Painless bleeding ☐ Bleeding after exercise
Associated symptoms: _____

UTI / Infection History

☐ Recurrent UTI ☐ Current urinary infection symptoms ☐ Fever/chills ☐ Flank pain
Number of episodes in the past year: _____ Last episode: _____
Previous urine cultures / antibiotics: _____

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PAGE 2 — STONES, PROSTATE, SEXUAL&TESTICULAR HEALTH

Kidney / Ureteric / Bladder Stones

☐ Previous stone ☐ Current suspected stone ☐ Passed stone ☐ Stone procedure
Side: ☐ Right ☐ Left ☐ Both Date/period: _____
Symptoms: ☐ Flank pain ☐ Groin pain ☐ Nausea/vomiting ☐ Haematuria ☐ Fever
Previous treatment: ☐ Observation ☐ ESWL ☐ Ureteroscopy ☐ PCNL ☐ Other: _____
Stone analysis / metabolic work-up performed? ☐ No ☐ Yes: _____

Prostate / Male Lower Urinary Tract Symptoms

☐ Weak stream ☐ Hesitancy ☐ Urgency ☐ Frequency ☐ Nocturia ☐ Dribbling
☐ Incomplete emptying ☐ Straining ☐ Retention ☐ Recurrent UTI
Previous prostate assessment: ☐ No ☐ Yes PSA history: _____
Previous prostate biopsy: ☐ No ☐ Yes Result/date: _____
Previous prostate medication/surgery: _____

Sexual&Reproductive Health

☐ Erectile difficulty ☐ Reduced libido ☐ Ejaculatory difficulty ☐ Pain with ejaculation
☐ Premature ejaculation ☐ Infertility concern ☐ Other: _____
Duration/onset: _____ Spontaneous morning erections: ☐ Yes ☐ No
Previous treatment/medication: _____
Any concerns about fertility, testes, sperm or previous semen analysis? _____

Testicular / Scrotal Symptoms

☐ Testicular pain ☐ Scrotal swelling ☐ Lump ☐ Heaviness ☐ Trauma
☐ Hydrocele ☐ Varicocele ☐ Previous torsion ☐ Previous testicular surgery
Side: ☐ Right ☐ Left ☐ Both Onset/duration: _____
Associated symptoms: _____

Incontinence / Pelvic Symptoms

☐ Stress leakage ☐ Urge leakage ☐ Mixed leakage ☐ Continuous leakage
☐ Bedwetting ☐ Post-void dribble ☐ Pelvic pain ☐ Bladder pain
Pads/absorbent products per day: _____ Impact on daily activities: _____

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PAGE 3 — MEDICAL HISTORY, MEDICATIONS&PREVIOUS UROLOGY

Medical History

☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Kidney disease ☐ Liver disease
☐ Neurological condition ☐ Stroke ☐ Cancer ☐ Blood disorder ☐ Thyroid disorder
☐ Recurrent infections ☐ Sleep disorder ☐ Other: _____
Other important medical conditions / operations: _____
_____

Surgical&Urological History

Previous operations/procedures: _____
☐ Kidney/ureter procedure ☐ Bladder procedure ☐ Prostate procedure
☐ Circumcision ☐ Testicular/scrotal surgery ☐ Hernia repair ☐ Other: _____
Previous hospital admissions relevant to current problem: _____

Medication&Allergy History

Current medicines (including over-the-counter/herbal medicines):
1. _____ Dose: _____ Frequency: _____
2. _____ Dose: _____ Frequency: _____
3. _____ Dose: _____ Frequency: _____
Drug/food/latex allergies: ☐ None known ☐ Yes: _____
Previous adverse drug reactions: _____

Family History

☐ Prostate cancer ☐ Kidney cancer ☐ Bladder cancer ☐ Testicular cancer
☐ Kidney stones ☐ Kidney disease ☐ Other hereditary urological condition
Relative / diagnosis / age if known: _____

Lifestyle&Relevant History

Smoking: ☐ Never ☐ Previous ☐ Current Alcohol: ☐ No ☐ Yes
Occupation: _____ Physical activity: _____
Typical daily fluid intake: _____ Caffeine/energy drinks: _____
Relevant occupational/chemical/radiation exposure: _____

Previous Investigations / Results

☐ Urine test/culture ☐ PSA ☐ Blood tests ☐ Ultrasound ☐ CT ☐ MRI
☐ X-ray ☐ Cystoscopy ☐ Urodynamics ☐ Semen analysis ☐ Other: _____
Important results / dates: _____
_____

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PAGE 4 — CLINICIAN ASSESSMENT&PLAN

Clinician Examination / Observations

Blood pressure: _____ Pulse: _____ Temperature: _____
Weight: _____ kg Height: _____ cm BMI: _____
Abdominal examination: _____
Genitourinary examination: _____
DRE / prostate assessment (if indicated): _____
Other examination findings: _____

Clinical Assessment / Differential Diagnosis

_____
_____
_____

Investigations Requested / Reviewed

☐ Urinalysis ☐ Urine culture ☐ FBC ☐ U&E/renal function ☐ PSA ☐ Other blood tests
☐ Ultrasound ☐ CT ☐ MRI ☐ X-ray ☐ Cystoscopy ☐ Urodynamics
☐ Semen analysis ☐ Stone/metabolic work-up ☐ Other: _____
Details / instructions: _____

Treatment / Management Plan

☐ Medication ☐ Lifestyle/fluid advice ☐ Antibiotics ☐ Pain management ☐ Observation
☐ Further procedure ☐ Surgery discussion ☐ Referral ☐ Follow-up investigation
Plan: _____
_____

Follow-Up&Safety-Netting

Follow-up date/interval: _____ Responsible clinician: _____
Patient advised to seek urgent care for relevant red-flag symptoms when appropriate: ☐ Yes
Additional instructions: _____
_____

Clinician Notes

_____
_____
_____
_____

Clinician Sign-Off

Clinician: _____ Signature: _____
Date: _____ Time: _____