UCSF TRANSITIONAL UROLOGY CLINIC

Thank you for choosing the UCSF Transitional Urology Clinic. This clinic was created to serve patients with urologic conditions diagnosed in childhood as they become adults and need to transition to an adult urology practice. Our clinic is jointly run by pediatric and adult urology to provide comprehensive urologic follow-up and healthcare for adults with congenital urologic conditions.

This clinic specializes in treating people with congenital urologic conditions like:

- Spina bifida
- Neurogenic bladder
- Bladder exstrophy/epispadias
- Differences in sex development (DSD)
- Cloacal anomalies
- Solitary kidney
- Vesicoureteral reflux
- Hypospadias
- Prune belly syndrome
- Posterior urethral valves
- Childhood urologic cancers

We ask that you complete the following new patient questionnaire to give us the necessary information to provide you with the best possible care. Your answers will help us better understand your situation and guide our decisions about what treatments are best for you. Please bring any medications and supplies with you so we know what you are using.

At the first visit, you will be seen jointly by Dr. Copp (a pediatric urologist) and Dr. Hampson (an adult reconstructive urologist). The goal is to thoroughly review your urologic care to-date, and to establish a plan moving forward. Part of this includes understanding your goals as well, so please let us know if there are particular issues you would like addressed at your visit.

When you arrive you will be asked to fill out an online questionnaire about your current symptoms. You can bring your family/friends into the room with you, although we will ask them to step out briefly so that we can perform a physical exam and make sure we address any concerns or questions you have that you might not want to talk about in front of them. The entire visit should last about an hour. On your way out we may ask you to stop by the lab or radiology to get bloodwork or imaging studies done. Follow-up visits will be with Dr. Hampson, with pediatric urologists involved on an as-needed basis.

If you have any questions, please call at 415-353-2200. We look forward to meeting you!

GENERAL INFORMATION:	
Patient Name:	Date of appointment:
Date of birth:	Race/Culture:
Gender:	Will be accompanied to office visit by:
Name of person completing this form:	Referred by:

UROLOGY DIAGNOSIS (check all that apply):	
☐ Spina bifida or myelomeningocele Do you have a VP shunt? Yes/No/Unsure ☐ Bladder exstrophy ☐ Epispadias ☐ Hypospadias ☐ Cloacal anomaly ☐ Vesicoureteral reflux ☐ Spinal cord injury: What level: _____ ☐ Solitary kidney	☐ Posterior urethral valves ☐ Neurogenic bladder ☐ Neurogenic bowel ☐ Prune belly syndrome ☐ Intersex or difference in sex development (DSD) ☐ GU malignancy:_____ ☐ Renal failure On dialysis? No/Yes – hemodialysis/peritoneal ☐ Other:

REASON FOR VISIT:	
☐ Yearly urology visit ☐ Discuss surgery/procedure ☐ Urinary leakage ☐ Difficulty catheterizing ☐ Renal/bladder stone ☐ Urinary tract infections ☐ Bowel issues ☐ Sexual or fertility questions ☐ Other:	Since your last visit or in the past 6 months, have you been seen in the emergency room, urgent care, or by another provider for: ☐ Difficulty catheterizing If so, did you require a procedure? ☐ Yes ☐No ☐ A bladder or kidney infection If so, did you require hospitalization? ☐ Yes ☐No ☐ Constipation or a problem with your bowels If so, did you require hospitalization? ☐ Yes ☐No
Recent testing: ☐ Imaging, done at: ☐ Labs, done at: ☐ Other:_____	I need refills on: ☐ Urology related medications My pharmacy is: ☐ Supplies My vendor is:

UROLOGIC SURGICAL HISTORY:

KIDNEY SURGERY

- ☐ Removal of entire kidney
  Date(s):_____
- ☐ Removal of part of kidney
  Date(s):_____
- ☐ Kidney transplant
  Date(s):_____
- ☐ Other:_____
  Date(s):_____

URETER SURGERY

- ☐ Ureteral reimplantation
  Date(s):_____
- ☐ Deflux injection for reflux
  Date(s):_____
- ☐ Other:_____
  Date(s):_____

STONE SURGERY

- ☐ Kidney stone removal
  Date(s):_____
- ☐ Bladder stone removal
  Date(s):_____
- ☐ Other:_____
  Date(s):_____

BLADDER SURGERY

- ☐ Bladder augmentation
  Date(s):_____
  Tissue used (*circle all that apply*):
  stomach, ileum/small intestine, colon/large intestine, unsure, other:_____
  Year when someone last looked in your bladder with a scope: ____
- ☐ Catheterizable channel creation
  Date(s):_____
  Tissue used for channel (*circle*): appendix, small intestine, unsure
  Revisions? No/Yes (procedure/dates:_____)
- ☐ Bladder removal Date(s):_____
- ☐ Vesicostomy Date(s):_____
- ☐ Ileal conduit Date(s):_____
- ☐ Indiana pouch Date(s):_____
- ☐ Bladder neck sling/ reconstruction/closure Date(s):_____
- ☐ Injection of bulking agents Date(s):_____
- ☐ Injection of bladder botox Date(s):_____
- ☐ Other:_____ Date(s):_____

URETHRAL SURGERY

- ☐ Urethral sling
  Date(s):_____
- ☐ Urethral sphincter
  Date(s):_____
- ☐ Injection of bulking agents
  Date(s):_____
- ☐ Other:_____
  Date(s):_____

BOWEL SURGERY

- ☐ MACE, ACE Malone
  Date(s):_____
- ☐ Chait tube
  Date(s):_____
- ☐ Colosomy
  Date(s):_____
- ☐ Other:_____
  Date(s):_____

OTHER PAST MEDICAL/SURGICAL HISTORY:	
☐ Any other medical conditions:	☐ Any other surgeries or procedures (and dates):

OTHER HEALTHCARE PROVIDERS:

Primary Care Provider & Clinic: _____

Neurosurgery Provider & Clinic: _____

Physical Medicine & Rehabilitation Provider & Clinic: _____

Nephrology Provider & Clinic:_____

Previous Urologist, Clinic: _____

Others:_____

COMMUNICATION, MOBILITY AND SELF CARE

Patient's preferred language: _____ ☐ Patient is non-verbal

Primary language in the household:_____

Does patient require any assistance with mobility? No/Yes

If yes, circle any that apply: wheelchair, walker, cane, other:_____

Describe patient's level of self-care (check one):

☐ Independent with self-care

☐ Patient performs most self-care but needs assistance with some tasks

☐ Caregiver performs most self-care but patient participates in some of it

☐ Caregiver performs all self-care without patient participation

URINARY SYSTEM	
Functional Abilities and Emptying Your Bladder	
Are you able to sense or feel when you need to empty your bladder: Yes/No/Unsure	Are you able to communicate your need to empty your bladder: Yes/No
Are you able to gather supplies and perform procedure that is needed to empty your bladder? ☐ Yes ☐ No; Describe the assistance you need: _____	Where do you empty your bladder (circle)? toilet, transfer onto bed/chair, seated in wheelchair
Do you need assistance or equipment to transfer onto the toilet? ☐ No ☐ Yes (circle): 1, 2, 3 people, lift	Are there places when your needs are not met that result in urinary accidents? ☐ No ☐ Yes; Describe: _____ _____

Current Voiding/Catheterizing	
How many times a day do you empty your bladder?	What are your normal output volumes (amount)?
How do you empty your bladder? Check all that apply: ☐ Spontaneously urinate: o into toilet o into brief o into urinal ☐ Crede maneuver ☐ Indwelling catheter o Foley o Suprapubic tube ☐ Intermittent catheterization o Urethra o Mitrofanoff/stoma	☐ Catheterization Who performs the catheterizations? You/Family member/Caregiver Size of catheter:_____ Using a new catheter each time: Yes/No Using lubricant: Yes/No Difficulties passing the catheter? Yes/No Comment: _____ Other difficulties cathing? Yes/No Comment:_____ _____
Any changes in your urine? ☐ No ☐ Yes: Color/odor/mucus/blood	Do you experience urgency? ☐ No ☐ Yes: describe

Stoma/Ostomy	
☐ No (skip to next section) ☐ Yes (continue below):	
Supplies Used:	Skin issues around stoma:
How often do you change the device:	Stenosis or Other Problems:

Urine Leakage	
☐ No (skip to next section) ☐ Yes (continue below):	
Briefs/Pads: No/Yes Full time/Night time/ As needed Number of briefs/pads per day:_____	Leaks are (circle): dribbles, small void, medium void, full void
I can feel when leaks occur: No/Yes	I am dry overnight: No/Yes
Leaks happen when I cough/laugh/sneeze/lift: No/Yes	Leaks happen more when I:

Bladder Medications

Are you currently on anticholinergics (bladder medications)? Yes/No

Which anticholinergic: Ditropan/Oxybutynin, Other: _____

List of other anticholinergics tried in the past:_____

Why were they discontinued:_____

Bladder Irrigations	
Do you perform bladder irrigations? ☐ No (skip to next section) ☐ Yes (continue below):	
How often:	Does mucous plug the cath? No/Yes
Solution Used:	Do you repeat until output is clear? No/Yes
Amount Used:	

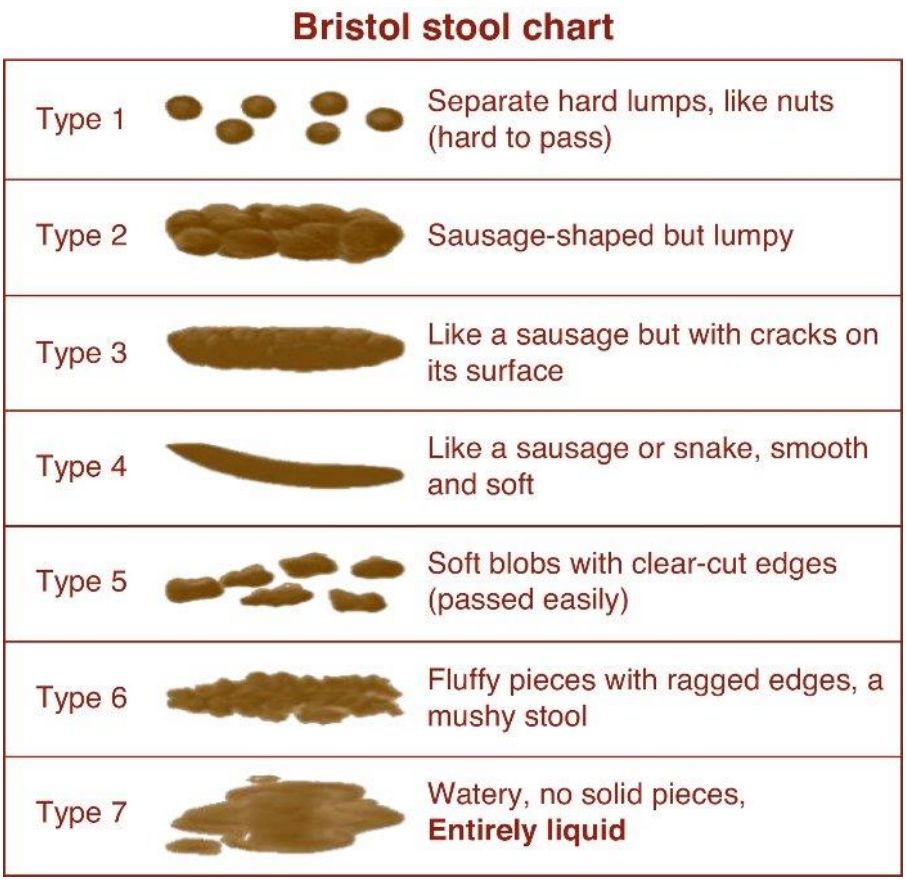
Urinary Tract Infections (UTI):	
Have you ever had a UTI? ☐ No (skip to next section) ☐ Yes (continue below):	
Date of last UTI:	Number of UTIs in the past year:
Were these UTIs treated with antibiotics? ☐ No ☐ Yes	Have you ever had a kidney infection (pyelonephritis) ☐ No ☐ Yes; date:_____
Did you need any of the following for your infection? ☐ Seen by another provider ☐ Seen in ER, Urgent Care ☐ IV antibiotics ☐ Admission to the hospital ☐ Admission to ICU	Symptoms of UTI I experience are (circle): fever, chills, change in urine color, strong odor of urine, pain with urination, increase frequency of urination, other: _____

Kidney or Bladder Stones	
Have you ever had a kidney or bladder stone? ☐ No (skip to next section) ☐ Yes (continue below): Have you had: ☐ Kidney stones ☐ Bladder stones	
History of stones: ☐ Passed on own ☐ Surgically removed	Current stones: ☐ No ☐ Yes ☐ Unknown

Bladder Program Satisfaction
How satisfied are you with your current urinary management? (0=terrible, 10=fantastic) 0 1 2 3 4 5 6 7 8 9 10

GASTROINTESTINAL	
Number of bowel movements a week:	Do you have constipation: No/Yes

Bristol Stool Type:



Do you have stool accidents? No/Yes

If yes, number of bowel accidents per week: _____

Current Bowel Program		
What aides do you use to have a bowel movement? (check all that apply) ☐ Digital stimulation (with a finger) ☐ Laxatives (Miralax, Senna, Milk of Magnesia, etc.) ☐ Fiber (Metamucil, Citrucel, Psyllium) ☐ Suppositories ☐ Enemas (in the rectum) ☐ Peristeen pump ☐ None	How often do you use your bowel program? ☐ Do not use a bowel program ☐ Daily ☐ Every other day ☐ Every _____ days ☐ Once a week	Do you need assistance completing your bowel program? ☐ Do not use a bowel program ☐ No ☐ Yes; Explain:
Brief/Pads for stool leakage: ☐ No ☐ Yes ☐ Full time/ Night time/ As needed ☐ Number of briefs/pads per day:	Toileting schedule: ☐ Not applicable ☐ Yes; Describe:	

ACE Malone/Chait Tube	
Do you have an ACE Malone (MACE) or a Chait tube? ☐ No (skip to next section) ☐ Yes (continue below):	
Frequency of use: ☐ Daily ☐ Every other day ☐ Every ____ days ☐ Every week	Solution used: ☐ Tap water ☐ Normal saline ☐ Do you add anything to the fluid? (circle all that apply) glycerine, salt, Miralax, other:
Amount of solution used:	Length of time it takes to produce a BM:
Have you had any of the following problems? (check all that apply) ☐ Difficulty getting catheter in ☐ Infection at stoma site needing antibiotics ☐ Bothersome leakage of stool ☐ Difficulty flushing ☐ Stopped producing BM ☐ Other: _____	

Bowel Program Satisfaction
How satisfied are you with your current bowel management? (0=terrible, 10=fantastic) 0 1 2 3 4 5 6 7 8 9 10

REPRODUCTIVE/SEXUAL HEALTH HISTORY	
Are you sexually active: ☐ Never ☐ In the past, but not currently ☐ Currently sexually active ☐ Total number of partners in lifetime: ____ ☐ # of partners within last 12 months: ____	☐ Male partners ☐ Female partners ☐ Skin contact ☐ Oral sex ☐ Vaginal sex ☐ Anal sex
Are you interested in discussing fertility or your ability to get pregnant/have a child? Yes/No	Are you interested in discussing contraception or preventing pregnancy? Yes/No
Females: ☐ Number of previous pregnancies: _____ ☐ Number of children: _____ ☐ First day of last menstrual cycle: _____ Contraception type: ☐ oral contraceptives (birth control pills) ☐ IUD (intrauterine device) ☐ contraceptive implant ☐ contraceptive injections ☐ condoms ☐ none ☐ other:_____ ☐ History of STI: yes/no/unsure ☐ Other concerns:_____ _____ _____	Males: ☐ Number of children: _____ ☐ History of STI: yes/no/unsure ☐ Other concerns:_____ _____ _____

SOCIAL HISTORY	
Legal Guardian:	Care Coordinator/Social Worker:
Living situation:	Work/social/day program:
Tobacco use: ☐ Pack per day _____ ☐ Number of years_____	
Relationship/Marriage/Friends:	Physical Activity:

FAMILY MEDICAL HISTORY

Family members with bowel, bladder, kidney illnesses and/or conditions:

_____

_____

MEDICATIONS AND ALLERGIES

Do you have any medical allergies? Yes/No

If yes, please list:_____

List all of your medications:

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS

Please circle if you experiencing any of the following:

Constitutional: fever, chills, weight loss, malaise/fatigue
HENT: hearing loss, neck pain, tinnitus
Eyes: blurred vision, double vision, photophobia
Respiratory: cough, sputum production, wheezing
Cardiovascular: chest pain, palpitations
Gastrointestinal: heartburn, nausea, vomiting, abdominal pain, diarrhea, constipation
Genitourinary: dysuria, urgency, frequency, urinary tract infections
Musculoskeletal: back pain, joint pain
Skin: itching, rash, skin irritation
Neurological: dizziness, tingling, focal weakness, headaches
Endo/Heme/Allergies: easy bruising or bleeding
Psychiatric/Behavioral: depression, nervousness, anxiety