UCSF UROLOGY
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
- Disorders of sex development
- Cloacal anomalies
- Vesicoureteral reflux
- Hypospadias
- Prune belly syndrome
- Posterior urethral valves
- Childhood urologic cancers

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. Follow-up visits will be with Dr. Hampson, with pediatric urologists involved on an as-needed basis.

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.

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:

REASON FOR VISIT:	
☐ Yearly urology visit ☐ Discuss surgery/procedure ☐ Urinary leakage ☐ Difficulty catheterizing ☐ Renal/bladder stone ☐ Urinary tract infections ☐ Bowel issues ☐ Other:	I need refills on: ☐ Urology related medications My pharmacy is: ☐ Supplies My vendor is:
Recent testing: ☐ Imaging, done at: ☐ Labs, done at: ☐ 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

PAST MEDICAL & SURGICAL HISTORY:		
Do you have a diagnosis of:		
☐ **Cerebral palsy** Do you have a baclofen pump? No/Yes/Unknown	☐ **Spina bifida** What level _____ ☐ Unknown	☐ **Spinal cord injury** What level _____ ☐ Unknown
☐ **Hydrocephalus** Do you have a shunt? No/Yes/Unknown	☐ **Tethered cord** Date of last release: _____ ☐ Unknown	☐ **Pregnancy** Dates: Vaginal or c-section delivery
☐ **Any other medical conditions**: ☐ Unknown _____ _____		
☐ **Past Surgeries**, Date, Surgeon & Location: ☐ Unknown _____ _____		

PAST UROLOGIC MEDICAL & SURGICAL HISTORY:	
Past Urologic Surgeries:	
☐ **Bladder augmentation:** Date: _____ ☐ Unknown Date when someone looked in your bladder with a scope last (cystoscopy): _____ ☐ Unknown Was the Ileum used in the augmentation? No/Yes/Unsure Are you on replacement for Vitamin B12? No/Yes/Unsure	☐ **Ileal conduit or Indiana pouch** Date: _____ ☐ Unknown Are you on replacement for Vitamin B12? No/Yes/Unsure
☐ **Mitrofanoff (catheterizable channel)** Date: _____ What was used to create the channel?: _____ ☐ Unknown	☐ **Solitary kidney** (Born with only one kidney, a horseshoe kidney, or have had one surgically removed)
☐ **Artificial urinary sphincter** Date: _____ ☐ Unknown	☐ **Botox injections to bladder** Date of last injection: _____ ☐ Unknown
☐ **Bladder neck sling or closure** Date: _____ ☐ Unknown	☐ **Stone removal:** kidney/bladder (circle) Date: _____ ☐ Unknown
☐ **Ureteral reimplantation** Date: _____ ☐ Unknown	☐ **Colostomy** Date: _____ ☐ Unknown
☐ **ACE (ACE Malone, MACE)** Date: _____ ☐ Unknown	☐ **Other surgery (list below)**
Procedure, Date, Surgeon Location: _____ Procedure, Date, Surgeon Location: _____ Procedure, Date, Surgeon Location: _____	

OTHER HEALTHCARE PROVIDERS:

Primary Care Provider & Clinic: _____

Neurosurgeon Provider & Clinic: _____

Physical Medicine & Rehabilitation Provider & Clinic: _____

Nephrologist Provider & Clinic:_____

Previous Urologist, Clinic: _____

Others:_____

_____

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

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:

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:	

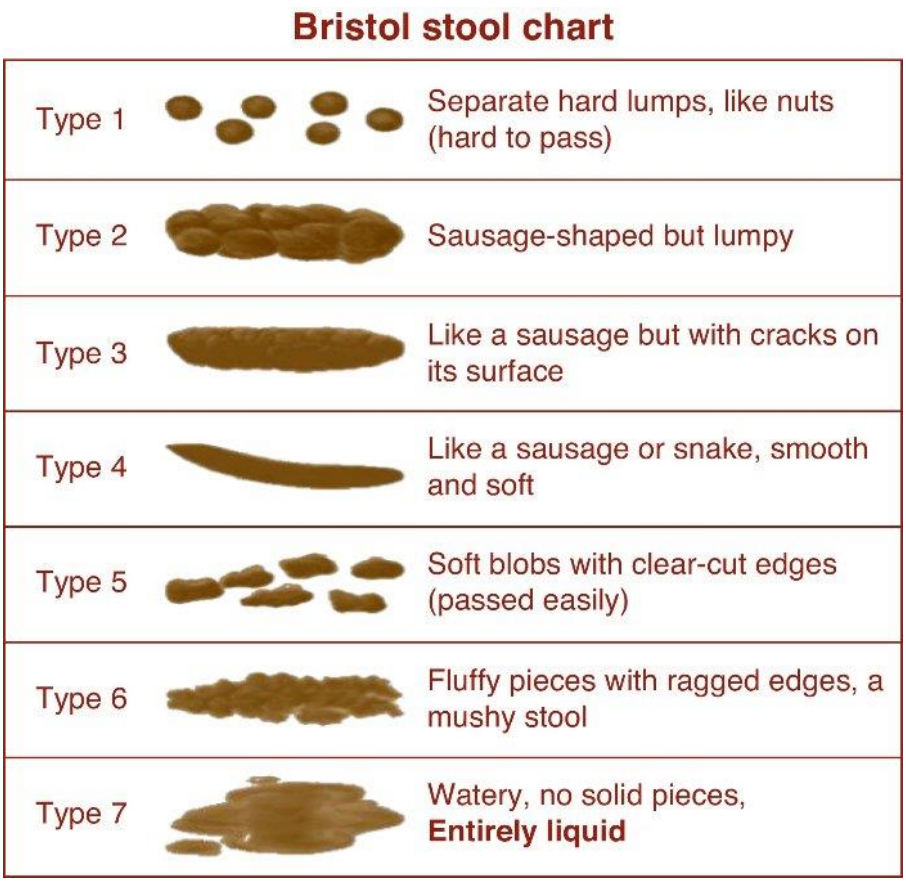
Urinary Tract Infections (UTI):	
Have you ever had a UTI? ☐ No (skip to next section) ☐ Yes (continue below):	
Date of last UTI:	Number of UTIs in the past year:
Were these UTIs treated with antibiotics? ☐ No ☐ Yes	Have you ever had a kidney infection (pyelonephritis) ☐ No ☐ Yes; date:_____
Did you need 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	
☐ 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

GASTROITESTINAL	
Date of last BM:	Number of bowel movements a week:

Bristol Stool Type:



Do you have constipation: No/Yes	Do you have stool accidents? No/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? ☐ Daily ☐ Every other day ☐ Every _____ days ☐ Every week	Do you need assistance completing your 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: ☐ No ☐ Yes; Describe:	

ACE/CHAIT	
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 flushing ☐ Infection at stoma site needing antibiotics ☐ Bothersome leakage of stool ☐ CHAIT fell out, needed replacement ☐ Stopped producing BM	

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: ☐ Prenatal vitamin ☐ Folic acid supplement ☐ Previous pregnancies: ☐ Number of children: ☐ Vaginal birth/C-section ☐ Use of contraceptives ☐ Protection against sexually transmitted infections (STI) ☐ History of STI: ☐ Sexual abuse: ☐ Other concerns:_____ _____ _____ ☐ First day of last menstrual cycle: _____	Males: ☐ Number of children: _____ ☐ Use of contraceptives ☐ Protection against sexually transmitted infections (STI) ☐ History of STI: ☐ Sexual abuse: ☐ 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____