Apex Physical Therapy & Wellness Center

"Keeping You in Peak Health!"

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MEN'S HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient Name: ________________________________ Date:________________

Patient History and Symptoms

Please fill in the following questionnaire to the best of your ability.
What is the primary complaint you are being seen for?____

____

When did this problem begin? (Date, approximate if known)____

Do you currently have the following symptoms?

Y/N Pelvic pain	Y/N Blood in urine
Y/N Low back pain	Y/N Kidney Infections
Y/N Bladder Infections	Y/N Latex sensitivity/allergy

Health History

Please CIRCLE any of the following health conditions that you now have or had in the past.
None

None	Unexplained weight loss	Tuberculosis	Cancer	Chemical dependency
Kidney disease	Diabetes	Smoker	Anemia	High blood pressure
Seizures	Stroke	Heart problems	Currently pregnant	Osteoporosis
Rheumatoid arthritis	History of fractures	Osteoarthritis	Asthma	Menopausal
Thyroid disease	Incontinence	Emphysema	Multiple sclerosis	Depression
Overweight	Hepatitis	Mental illness	Other:	

Please list any medications that you are taking (over the counter and prescriptions) and list the dosage (Please be specific)

Medication **Dosage**

____

____

____

Please list any surgeries you have had or CIRCLE no surgeries

____

____

No surgeries or not related to current information

Urological History

1. How many times do you urinate during the day? _________times per day
2. How often do you wake up to urinate after going to bed? _________times
3. After emptying your bladder do you have the feeling that you have not finished? Yes No
4. Do you experience any leakage of urine? Yes No
5. After you urinate, do you have any dribbling? Yes No

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6. Please CIRCLE if you leak urine during the following situations:
   Walking　Running　Urgency　Changing from sitting to standing
   Lying Down　Exercise　Intercourse　Straining/lifting　Cough/Sneeze/Laugh
7. What amount of leakage do you experience? (CIRCLE)
   Drops　More than drops　Flood　Leak continually
8. Do you use any protection (pad) for urine leakage?　Yes　No
   If yes, how many per day?____________________

9. Do you ever wet the bed while sleeping?　Yes　No
10. Do you have sensation or awareness when you experience leakage of urine?　Yes　No
11. Do you find it difficult to begin urinating?　Yes　No
12. Do you have to strain to pass urine?　Yes　No
13. Do you have a slow, stop/start or hesitant urinary stream?　Yes　No
14. Is the volume of urine passed usually: (CIRCLE)　Large　Average　Small　Very Small
15. Fluid intake (one glass is 8 oz or one cup)
   ___ of glasses per day (all types of fluid)
   ___ of caffeinated glasses per day
   Typical types of drinks ____

Bowel Symptoms

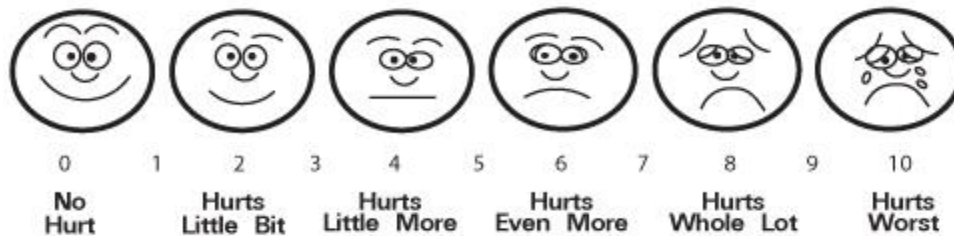
16. How often do you have a bowel movement?: ___ per day __ per week.
17. Do you strain to go? Y/N____________
18. Please CIRCLE the bowel symptoms you are experiencing:
   Diarrhea　Constipation　Incontinence　Laxative Use
   Increased Fiber Use　Stool Softener Use　Leaking Gas (Flatulence)
19. Do you have pain with bowel movements?　Yes　No
20. Most common stool consistency? (CIRCLE)　Liquid　Soft　Firm　Pellets　Other

Sexual Dysfunction

1. Do you have any difficulty attaining an erection?　Yes　No
2. Do you difficulty maintaining an erection?　Yes　No
3. Do you experience any pain with intercourse?　Yes　No

Describe any other sexual pain you may have?

On a scale of 0-10 (0 being no pain, 10 being extreme pain) rate your pain (Circle the number)?



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