

Mens's Health History and Screening Questionnaire

Patient Name:						
Patient History and Symp						
	questionnaire to the best o plaint you are being seen for					
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When did this problem be	egin? (Date, approximate if I	known)				
Do you currently have the Y N Pelvic Pain Y N Low back pain Y N Bladder Infecti Y N Internal Foreig	Y N Blood Y N Kidney	Infections sensitivity/allergy	ı, etc)			
If you answered "Yes" to a	any of the previous question	ns, please explain:				
Health History Please CHECK any of the f	ollowing health conditions t	that you now have	or had in the past.			
None	Tuberculosis	Cancer	Seizures	Chemical dependency		
Kidney disease	Diabetes	Smoker	Anemia	Unexplained weight loss		
Heart disease	Rheumatoid arthritis	Stroke	Osteoporosis	High blood pressure Osteoarthritis/ Osteopen		
History of fractures	Thyroid disease	Incontinence	Asthma			
Multiple sclerosis	Overweight	Emphysema	Depression	Mental illness		
Hepatitis	Migraines	UTI's				
Other:						
Please list any medications Medication	that you are taking (over the	counter & prescript		ge (Please be specific) osage		
Please list any surgeries ye	ou have had or o surge	eries				
No surgeries or not related to cu	rrent information					



1. How many times do you urinate during the day?	Urc	ological History								
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 6. Please CHECK if you leak urine during the following situations:	1.	How many times do you urinate during the day?		_times pe	r day					
4. Do you experience any leakage of urine? Yes No 15. After you urinate, do you have any dribbling? Yes No Please CHECK if you leak urine during the following situations: Walking Running Urgency Changing positions (sit→stand) Lying Down Exercise Intercourse Straining/lifting Cough/Sneeze/Laugh No You wat amount of leakage do you experience? (CHECK) Drops More than drops Flood Leak continually Do you use any protection (pad) for urine leakage? If yes, how many per day? 9. Do you use any many per day? 9. Do you ever wet the bed while sleeping? Yes No 10. Do you find it difficult to begin urinating? Yes No 11. Do you find it difficult to begin urinating? Yes No 12. Do you have a slow, stop/start or hesitant urinary stream? 14. Is the volume of urine passed usually: (CHECK) Large Average Small Very Small 15. Fluid intake (one glass is 8 oz or one cup)	2.									
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 Do you have difficulty maintaining an erection? Do you experience any pain with intercourse? Yes No 			Yes	No						
3. Do you experience any pain with intercourse? Yes No										
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On a scale of 0-10 (0 being no pain, 10 being extreme pain) rate your pain (CLICK the number)?

