Men's Health History

Physical Therapy & Wellness Center

Patient Name: _____ **Date:** _____

Please fill in the following questionnaire to the best of your ability.

Patient History and Symptoms

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?

☐ Yes	☐ No	Bladder Infections	☐ Yes	☐ No	Latex sensitivity/allergy
☐ Yes	☐ No	Blood in Urine	☐ Yes	☐ No	Low Pain Back
☐ Yes	☐ No	Kidney Infections	☐ Yes	☐ No	Pelvic Pain

Health History

Please **CIRCLE** any of the health conditions that you now have or have had in the past.

None	Depression	History of Fractures	Osteoarthritis / Osteopenia	Smoker
Anemia	Diabetes	Incontinence	Osteoporosis	Stroke
Asthma	Emphysema	Kidney Disease	Overweight	Thyroid Disease
Cancer	Hearth Problems	Mental Illness	Rheumatoid Arthritis	Tuberculosis
Chemical Dependency	Hepatitis	Migraines	Seizures	Unexplained Weight Loss
Covid	High Blood Pressure	Multiple Sclerosis	Other: _____	

Please list any surgeries 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

Flip Over

6. Please **CHECK** if you leak urine during the following situations:

☐ Changing from sitting to standing ☐ Cough/Sneeze/Laugh ☐ Exercise ☐ Intercourse
☐ Lying Down ☐ Running ☐ Straining/Lifting ☐ Urgency ☐ Walking

7. What amount of leakage do you experience? **CIRLCE**

Drops More than drops Flood Leak Continually

8. Do you use any protection (pads) for urine leakage? ☐ Yes ☐ No

If yes, how many per day? _____

9. Do you ever wet the bed while sleeping?
10. Do you have sensation or awareness when you experience leakage of urine?
11. Do you find it difficult to being urinating?
12. Do you have to strain to pass urine?
13. Do you have a slow, stop/start, or hesitant urinary stream?
14. Is the volume of urine passed usually: **CIRLCE**

Large Average Small Very Small

15. Fluid intake (one glass is 8oz or one cup)

_____ glasses per day (all types of fluids)

_____ glasses 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? ☐ Yes ☐ No
18. Please **CHECK** the bowel symptoms you are experiencing

☐ Constipation ☐ Diarrhea ☐ Incontinence ☐ Increased Fiber Use
☐ Laxative Use ☐ Leaking Gas (Flatulence) ☐ Stool Softener Use

19. Do you have pain with bowel movements? ☐ Yes ☐ No
20. Most common stool consistency

Liquid Soft Firm Pellets

Other (please describe): _____

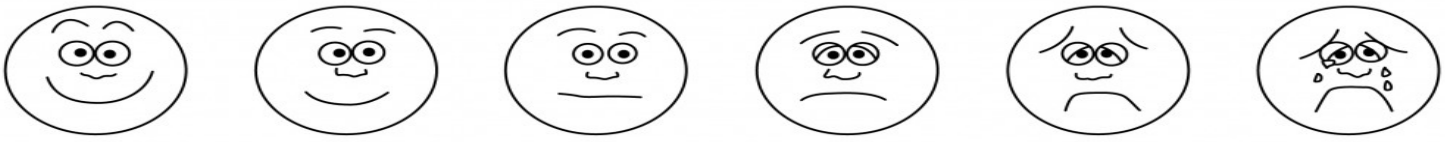
Sexual Dysfunction

21. Do you have any difficulty attaining an erection? ☐ Yes ☐ No
22. Do you have any difficulty maintaining an erection? ☐ Yes ☐ No
23. Do you experience any pain with intercourse? ☐ Yes ☐ No

Please 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)?



0 **No Hurt** **1** **2** **Hurts Little Bit** **3** **4** **Hurts Little More** **5** **6** **Hurts Even More** **7** **8** **Hurts Whole Lot** **9** **10** **Hurts Worst**