MALE PATIENT QUESTIONNAIRE/HISTORY FORM

Name: _____ Age: _____

Today's Date: _____ Family Physician: _____

This questionnaire is very important! These questions are designed to aid your Doctor in assessing your problem, so please try to answer each question concisely and accurately. All information in this report and in this office is kept in the strictest confidence.

CHIEF COMPLAINT: What is the main reason for your visit today? Be precise.

_____

_____

_____

Urinary Symptoms: Check appropriate box		Yes	No
1.	When you urinate, does the stream start immediately?	☐	☐
2.	When the stream starts to flow, does it come out (☐ Check one) FAST ☐ MEDIUM ☐ SLOW ☐		
3.	Once the stream is flowing, does it flow: CONTINUOUSLY?	☐	☐
4.	Do you push or strain to urinate?	☐	☐
5.	When you are finished, do you feel empty?	☐	☐
6.	Do you awaken at night to urinate? If YES, how many times? _____	☐	☐

		Yes	No
7.	Do you leak urine? If YES, how many pads do you use per day? _____	☐	☐
8.	Does it burn or sting when you urinate?	☐	☐
9.	How often do you urinate during the day? (every 30 minutes, every 2 hours etc.) _____		
10.	Do you get the urge to urinate so bad that you do not think you will get to the Bathroom in time?	☐	☐
11.	Have you ever had a sexually transmitted disease? (Circle one - gonorrhea, chlamydia, herpes, genital warts, other _____)	☐	☐
12.	Have you ever had an infection in your urinary tract: (Kidneys, Bladder, Prostate)?	☐	☐
13.	Is there pain in the:		
	a. Lower abdomen (bladder)?	☐	☐
	b. Groin?	☐	☐
	c. Testicles?	☐	☐
	d. Behind the scrotum or testicles	☐	☐

		Yes	No
KIDNEY STONES			
1.	Do you have pain in the flank or kidney area? If YES, Left _____ Right _____	☐	☐
2.	Have you ever had a kidney stone? If not, go to the next section.	☐	☐
	If YES a. When? _____ b. How many? _____ c. Passed spontaneously? _____ d. Removed 1. Surgically: _____ 2. Basket? _____ e. Lithotripsy (shock waves)? _____		
	What was the stone made of? Calcium? _____ Uric Acid? _____ Other? _____		
	Was a metabolic evaluation done to determine the cause of the stone?	☐	☐
	Were you placed on stone prevention therapy? What? _____	☐	☐

HEMATURIA			**YES**	**NO**
1.	Have you seen blood in your urine? (If no, go to question #3)		☐	☐
	If YES	a. Was the blood only at the beginning of the stream?	☐	☐
		b. Throughout the stream?	☐	☐
		c. At the end of the stream?	☐	☐
	Was the bloody urine (check all that apply)			
		a. Tea colored ☐		
		b. Rose wine/ cranberry colored ☐		
		c. Burgundy wine colored ☐		
		d. Clots ☐		
2.	Was there any pain or burning with the bloody urine?		☐	☐
3.	Has a doctor found blood in your urine under a microscope?		☐	☐

ERECTILE DYSFUNCTION		**YES**	**NO**
1.	Do you have problems with erections? If NO, go to the next section.	☐	☐
	If YES…		
	a. Do you awaken in the morning or night with a good erection?	☐	☐
	b. Does your sexual partner give you plenty of stimulation (oral, manual) to help you achieve or maintain an erection?	☐	☐
	c. Do you have trouble obtaining an erection?	☐	☐
	d. Do you have trouble maintaining an erection?	☐	☐
	e. Do you have a curvature with erections?	☐	☐
	f. Do you have painful erections?	☐	☐
	g. Is sex an important part of your life?	☐	☐
	On a scale of 1 to 10, rate the quality of your erections now (10 being when you were 18 years old) _____ .		
	When attempting intercourse, how many times out of every 10 tries will you successfully penetrate and achieve orgasm? _____		

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS

Have you ever had or do you currently have any serious problems with…	**YES**	**NO**	**DESCRIBE**
HEART (chest pain, heart attack, murmur, irregular heartbeat, high blood pressure, heart failure, etc.)	☐	☐	
LUNGS (shortness of breath, emphysema, asthma, TB, pneumonia, etc.)	☐	☐	
STOMACH / LIVER (ulcers, bleeding, hepatitis, etc.)	☐	☐	
BOWELS (change in bowel habits, CONSTIPATION, diarrhea)	☐	☐	
BRAIN / NERVOUS SYSTEMS (stroke, seizure, "blackout spells," etc.)	☐	☐	
GLANDS (DIABETES, thyroid, gout)	☐	☐	
MUSCULOSKELETAL (arthritis, disc disease)	☐	☐	
EYES / EARS / NOSE / THROAT	☐	☐	
BLOOD OR CLOTTING PROBLEMS	☐	☐	
PSYCHIATRIC (depression, mental illness)	☐	☐	
CONSTITUTIONAL (unexplained weight loss, fevers, chills, night sweats)	☐	☐	
CANCER (kidney, bladder, prostate, testicle, penis)	☐	☐	
SKIN (rash, psoriasis, hives)	☐	☐	
Do you have any artificial joints or heart valves?	☐	☐	

SURGICAL HISTORY

OPERATION	DATE	SURGEON
1.		
2.		
3.		
4.		
5.		

Have you ever had a blood transfusion? Yes ☐ No ☐ If so, when? _____

MEDICATIONS

NAME OF MEDICATION	DOSAGE (mg)	HOW TAKEN (ex: one pill twice a day)
1.		
2.		
3.		
4.		
5.		
6.		

ALLERGIC REACTIONS

Please list all medications that give you a rash, hives, wheezing, difficulty breathing, shock, etc.

NAME OF MEDICATION	SPECIFY TYPE OF REACTION
1.	
2.	
3.	

DRUG INTOLERANCES

Please list all medications that caused side effects such as nausea, vomiting, stomach upset, diarrhea, headache, etc.

NAME OF MEDICATION	SPECIFY TYPE OF REACTION
1.	
2.	
3.	

FAMILY HISTORY

Please list any diseases that run in your family such as cancer, kidney stones, diabetes, etc.

DISEASE	FAMILY MEMBER
1.	
2.	
3.	
4.	

SOCIAL HISTORY	YES	NO
1. Do you smoke, or did you ever smoke? How much? _____ packs / day How long? _____ years Quit when? _____	☐	☐
2. Do you drink? How much? _____	☐	☐
3. Do you use street drugs? What type? _____ Do you use needles? _____	☐	☐
4. Do you engage in "high risk" sexual behavior?	☐	☐
5. Are you HIV positive or do you have AIDS?	☐	☐
6. Circle one - employed/ retire/ homemaker/ unemployed Type of employment? _____	☐	☐
7. Circle one - married/ single/ divorced	☐	☐

☐ **Check your score for each below**

		0	**1**	**2**	**3**	**4**	**5**
		Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1	Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you have finished urinating?	☐	☐	☐	☐	☐	☐
2	Over the past month or so, how often have you had to urinate again less than two hours after you have finished urinating?	☐	☐	☐	☐	☐	☐
3	Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	☐	☐	☐	☐	☐	☐
4	Over the past month or so, how often have you found it difficult to postpone urination?	☐	☐	☐	☐	☐	☐
5	Over the past month or so, how often have you had a weak urinary stream?	☐	☐	☐	☐	☐	☐
6	Over the past month or so, how often have you had to push or strain to begin urination?	☐	☐	☐	☐	☐	☐
7	Over the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None ☐	1 time ☐	2 times ☐	3 times ☐	4 times ☐	5 times or more ☐

Total your score here _____

Total Symptom Score = Sum of questions 1 to 7 = _____