Patient Questionnaire for Men

Please fill out the following questionnaire to the best of your ability prior to your first appointment. Your physical therapist will review your responses during your initial visit.

Patient Name _____ **Date** _____
Name of primary care physician _____
Referred to Physical Therapy by:
_____

What is the reason for your visit? _____
_____

How did you hear about Kamin Physical Therapy? doctor's referral; word of mouth; website; phone book; other: _____

Urological History **Circle Yes or No**

1. **Have you had problems or an infection in your prostate?** Y N
2. Have you had problems or an infection within your Testes? Y N
3. Were either of your testicles undescended at birth? Y N
   If yes, did you have surgery for this? Y N
4. Have you had a traumatic injury to your penis or testicles? Y N
5. Have you had a vasectomy? Y N
   If yes, at what age? _____
6. Did you have it reversed? Y N
7. Have you had a Prostate exam? Y N

Medical History/Family History
Do you or any of your relatives have a history of the following?

	You	Relative	(relation to you)
Anemia	____	_____	_____
Bleeding tendency	____	_____	_____
Cancer	____	_____	_____
Colitis/Bowel trouble	____	_____	_____
Depression	____	_____	_____

Diabetes	____	_____	_____
Glaucoma	____	_____	_____
Heart Disease	____	_____	_____
High Blood Pressure	____	_____	_____
Kidney Disease	____	_____	_____
Liver disease/Hepatitis	____	_____	_____
Lung Disease/Asthma	____	_____	_____
Migraine Headaches	____	_____	_____
Osteoporosis	____	_____	_____
Psychiatric disorder	____	_____	_____
Seizures/Epilepsy	____	_____	_____
Thyroid Disease	____	_____	_____
Stroke	____	_____	_____
Ulcers	____	_____	_____
Vein trouble/Blood clots	____	_____	_____

Other:_____

Have you had any previous fractures? Y N

Any other serious injuries? Y N

Have you had any blood transfusions? Y N

Surgical history:

Please list any surgeries not mentioned previously in this questionnaire:

Surgical procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications

List medications or supplements you are currently taking:

_____

_____

List any drug allergies:

_____

_____

Are you allergic to latex: **Y N**

Bladder Symptoms **Circle Yes or No**

1. Have you ever filled out a bladder diary? Y N
2. Do you have frequent urinary tract infections? Y N
3. Do you lose urine when you cough/sneeze/laugh? Y N
4. Do you lose urine during physical activity like running, jumping, lifting? Y N
5. If you lose urine, how much do you leak? c*ircle one*: small, medium, large
6. Do you ever have strong, uncontrolled urges to urinate? Y N
   If so, how many times per day _____
7. Do you ever lose urine because you cannot make it to the bathroom in time? Y N
8. How many times do you urinate (void) throughout the day? _____
9. How many times do you void at night? _____
10. Does your bladder wake you up at night? Y N
11. How large are your voids? *circle one*: small, medium, or large
12. Do you strain to urinate or empty your bladder? Y N
13. Do you have difficulty starting a stream of urine? Y N
14. Do you have a slow or weak flow? Y N
15. Do you have splitting of the stream or dribbling? Y N
16. Do you have pain or burning with urination? Y N
17. Do you have blood in your urine? Y N
18. Do you wear a pad for leakage? Y N
    If so, how many times do you change the pad daily? _____

19. How much fluid do you drink per day? _____

20. Do you drink caffeinated beverages regularly? Y N

21. Do you drink alcohol regularly? Y N

Bowel Symptoms **Circle Yes or No**

1. How often do your move your bowels per day? _____ week? _____

2. How often do you move your bowels at night? _____

3. Do you have constipation? Y N

4. Do you strain/push out with bowel movements? Y N

5. Do you have pain with bowel movements? Y N

6. Do you have blood in your stools? Y N

7. Do you often have diarrhea? Y N

8. Do you leak and stain your underwear with feces? Y N

9. Can you tell the difference between a bowel movement and passing gas? Y N

10. Most common stool consistency? c*ircle one*: liquid, soft, firm, pellets, or other _____

Pain Symptoms **Circle Yes or No**

1. Do you have pain with prolonged sitting? Y N

2. Do you have pain with prolonged standing? Y N

3. Do you have pain wearing tight clothing? Y N

4. Do you have pain in the area between the rectum and penis? Y N

5. Do you have pain in the genital area? Y N

6. Do you experience abdominal pain? Y N

7. Do you have a history of back pain? Y N

8. Do you have head/neck pain? Y N

9. Do you clench your teeth or have jaw pain? Y N

10. Do you have a history of headaches/migraines? Y N

11. List any other areas of pain _____

Please circle the level/number of pain you experience on a daily basis:

[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____]
0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain

Sexual History **Circle Yes or No**

1. Are you currently sexually active? Y N

2. Do you have a desire to be sexually active? Y N

3. Is sexual intercourse satisfactory to you? Y N

4. What is your sexual preference? *Circle one*: Male, Female, Both

5. Do you have pain with sexual intercourse? Y N
   If yes, describe the pain felt during sexual intercourse: burning, throbbing, stabbing, other _____

6. Are you able to achieve an erection easily? Y N

7. Are you able to maintain an erection through completion of intercourse? Y N

8. Do you have pain with an erection? Y N

9. Do you have difficulty with ejaculation/orgasm? Y N

10. Do you ever lose urine during sexual intercourse? Y N

11. Do you ever have bowel incontinence during sexual intercourse? Y N

12. Do you have a history of physical, mental or sexual abuse? Y N

13. Do you have a history of sexually transmitted diseases? Y N
    If yes, please describe_____

Lifestyle **Circle Yes or No**

1. Do you have a balanced diet? Y N

2. Are there foods in your diet that aggravate your symptoms? _____

3. What is your occupation? _____

4. Do you spend long hours driving each day? Y N

5. Do you stand or sit for long periods each day? Y N

6. Have you ever fallen on/broken your tailbone? Y N

7. Do you exercise? Y N
   If so, how many times per week _____

8. Do you smoke? Y N
   If yes, how many packs per day _____

9. Do you use recreational drugs? Y N

10. Do your symptoms impact your social life? Y N

11. Do your symptoms make you sad or depressed? Y N

12. Do your symptoms interfere with family or household responsibilities? Y N

Sleeping patterns: **Circle Yes or No**

1. How many hours of sleep do you get nightly? _____

2. Do you wake up after a night's sleep feeling rested? Y N

3. How many hours of sleep do you need to feel rested? _____

4. Do you have difficulty falling asleep? Y N

5. Do you drink caffeine or alcohol within three hours before bedtime? Y N

6. Do you have night sweats? Y N

7. Are you a restless sleeper? Y N

8. Do you wake up in the morning with headaches? Y N

9. What is your usual sleep position? _____

10. Do you often remember dreaming? Y N

11. Does your partner keep you awake by their sleeping habits? Y N

12. Do you snore? Y N

13. Do you have a hard time breathing when you sleep? Y N

List any additional comments or concerns that were not addressed in the questionnaire:

_____
_____
_____
_____
_____

Thank you for your time, please contact Kamin Physical Therapy at (847) 384-6804 with any further questions or concerns.