inTouch Physical Therapy

Men's Health Screening Questionnaire

To ensure a thorough evaluation, please provide this important information about your medical history.

Name _____ **DOB** _____ **Age** _____ **Height** _____ **Weight** _____

How would you **rate** your general health? (*circle one*) Poor / Fair / Good / Excellent

What brings you to PT today? (brief description of symptoms) _____

_____

Onset Date _____ **Sudden** / **Gradual** (*circle*) Are your symptoms: **New** / **Recurring** (*circle)*

Have you had treatment/ diagnostic tests for this? **Y N** If yes, what? _____

What is your *GOAL* with Physical Therapy? _____

_____

Do you have a history of sexual abuse or trauma? Y N

Do you have frequent urinary tract infections? Y N

Do you have any product allergies? (ie latex) Y N

If yes, please list: _____

Test Results

Urodynamic Y N date/ results: _____

Cystoscope Y N date/ results: _____

Urine tests Y N date/ results: _____

Bowel tests Y N date/ results: _____

X-Ray, MRI, CT Y N date/ results: _____

Have you experienced these in the **PAST 2 WEEKS?** (*circle*)

Chills or Fever	Bowel/ bladder changes
Fatigue	Dizziness
Headaches	Nausea/ Vomiting
Night sweats	Numbness/ Tingling
Sleep disturbance	Swelling
Unexplained weight loss/ gain	Weakness

HAVE YOU EVER BEEN DIAGNOSED WITH:

Diabetes	Y	N	Stroke	Y	N
Fibromyalgia	Y	N	Scoliosis	Y	N
Osteoarthritis	Y	N			
Osteoporosis/ osteopenia	Y	N			

Cancer Y N

Type _____ Date_____

Heart Problems Y N

Type _____ Date_____

Lung Problems Y N

Type _____ Date_____

Infectious Disease Y N

Type _____ Date_____

Other: _____

Which **Over-the-Counter** and **Prescription** medications have you taken in the past **3-4 weeks**? Please list:

OTC: _____

_____

Prescription: _____

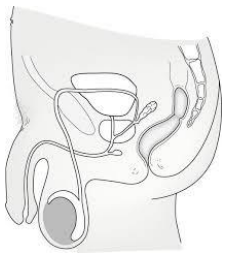
_____

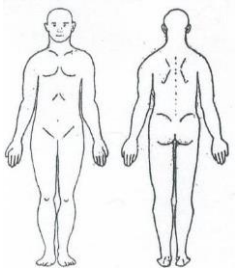
INDICATE and RATE YOUR PAIN with each activity:

(☺ 0 1 2 3 4 5 6 7 8 9 10 ☹)

Sexual intercourse	Y	N	____/10
Erection	Y	N	____/10
Orgasm	Y	N	____/10
Other _____			____/10
Do you have abdominal pain?	Y	N	____/10
Do you have back, leg, or groin pain?	Y	N	____/10

Please INDICATE your AREA(S) of pain:





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List **ANY previous SURGERIES/ INJURIES/ MEDICAL CONDITIONS** (**even if not directly related**)

DATE SURGERIES/ INJURIES/ MEDICAL CONDITIONS REASON

_____

_____

_____

_____

_____

_____

What makes your symptoms BETTER? (*please circle*)

Heat	Sitting	Nighttime	Exercise	Walking
Ice	Standing	Medication	Stretching	Resting
Enema	Massage	Relaxation	Laxatives	BM

Hot bath Urination Position changes
Nothing changes my symptoms
Other: _____

BLADDER SYMPTOMS, Do you:

Wet the bed?	Y	N
Have burning/ pain with urination?	Y	N
Strain to empty your bladder?	Y	N
Have a frequent, strong urge to urinate?	Y	N

~Number of times you urinate per day: _____

When you leak, how much do you leak? (*circle*)

Droplets Need to change underwear
Need to change pad

Feel unable to empty bladder?	Y	N
Have difficulty starting stream of urine?	Y	N
Have pain with a full bladder?	Y	N

~Number of times you urinate at night: _____

Do you lose urine when you:

Cough/ sneeze/ laugh?	Y	N
Have intercourse?	Y	N
Walk to the bathroom?	Y	N
Enter your home/ key in door?	Y	N
Feel nervous or anxious?	Y	N
Lift/ exercise/ dance/ jump?	Y	N
Running?	Y	N

Other: _____

What form of protection do you wear? (*circle*):
None
Minimal (tissue paper/panty liner)
Moderate (absorbent product/ maxi pad)
Maximum (specialty product/ diaper)

Signature: _____
Date:_____

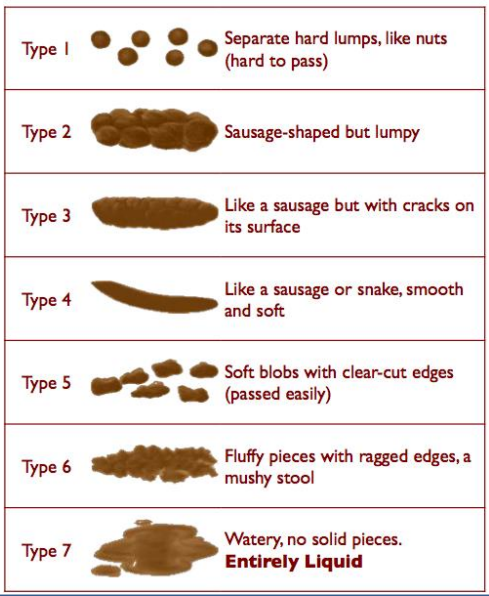
BOWEL SYMPTOMS, Do you:

Leak/ stain feces?	Y	N
Leak gas by accident?	Y	N
Strain to have a bowel movement?	Y	N
Have pain with bowel movements?	Y	N
Have frequent, strong urges to move bowels?	Y	N
Take laxatives/ enema regularly?	Y	N

How often do you move your bowels?
____ times per day OR week (*please circle*)

Please *circle* **your most common stool consistency** on the Bristol Stool Chart:

Bristol Stool Chart



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