PATIENT NAME: ____________________________ DOB:________________ DATE:_______________

Male Symptom Monitor

Occupation:_________________________ Recreational Activities:________________________________

Presenting problems:

1. ____

2. ____

When did this start? ____

Please fill out each section that is relevant to your problem

Have you had any of the following medical procedures?;

Appendectomy	□ Yes	□ No	Hernia repair	□ Yes	□ No	Vasectomy	□ Yes	□ No
Hemorrhoid banding	□ Yes	□ No	Prostatectom y	□ Yes	□ No	Cystoscopy	□ Yes	□ No
Urodynamics	□ Yes	□ No	Colostomy	□ Yes	□ No	Bowel resection	□ Yes	□ No
Gallbladder removal	□ Yes	□ No	Other					

Bladder Symptoms:

Did you have problems with your bladder during childhood?	□ Yes □ No □ Sometimes
Do you have leakage associated with sneezing, coughing, running	
and/or laughing?	□ Yes □ No □ Sometimes
Do you have leakage during intercourse?	□ Yes □ No □ Sometimes
Do you feel really strong sensations prior to voiding but don't leak?	□ Yes □ No □ Sometimes
Does your leakage occur after having a strong urge that feels	
uncontrollable?	□ Yes □ No □ Sometimes
Do you have pain when your bladder fills?	□ Yes □ No □ Sometimes
Does your pain improve when you void?	□ Yes □ No □ Sometimes
Do you have pain when you void?	□ Yes □ No □ Sometimes
Do you have to strain in order to empty your bladder?	□ Yes □ No □ Sometimes
Do you have difficulty starting your urine steam?	□ Yes □ No □ Sometimes
Do you have dribbling after you get up from the toilet?	□ Yes □ No □ Sometimes
Do you stand to void?	□ Yes □ No □ Sometimes
Do you have incomplete emptying when you void and feel like you	
have to go again soon?	□ Yes □ No □ Sometimes
Do your bladder problems cause you to leak at night?	□ Yes □ No □ Sometimes
Does your incontinence fluctuate?	□ Yes □ No □ Sometimes
Does your incontinence require you to wear pads?	□ Yes □ No □ Sometimes
If you answered yes or sometimes, how often?	
Do you void during the day more than the average person (5-7x/day)?	□ Yes □ No □ Sometimes

PATIENT NAME: ____________________________ DOB:________________ DATE:_______________

If you answered yes or sometimes, how often?	
Do you need to get up at night to void?	□ Yes □ No □ Sometimes
If you answered yes or sometimes, how many times?	

Fluid intake in 24 hours:

#__________ cups of water/day #__________cups of coffee/day

#__________cups of tea/day #__________cups of other fluids/day

Do you have any food allergies or sensitivities?

____

____

____

Digestion & Bowel Function:

What is the frequency of your bowel movements?	
Do you feel the urge to move your bowels?	□ Never □ Seldom □ Always
Do you have constipation?	□ Never □ Seldom □ Always
Do you strain to have a bowel movement?	□ Never □ Seldom □ Always
Do you have loose stools/diarrhea?	□ Never □ Seldom □ Always
Do you have bowel urgency that is difficult to control?	□ Never □ Seldom □ Always
Do you lose control of your bowels?	□ Never □ Seldom □ Always
Do you have incomplete emptying?	□ Never □ Seldom □ Always
Do you have pain with a bowel movement?	□ Never □ Seldom □ Always
Do you have pain after a bowel movement?	□ Never □ Seldom □ Always
Does it take longer than 5 minutes to have a bowel movement?	□ Never □ Seldom □ Always
Do you have bloating? (Increased pressure in abdomen)	□ Never □ Seldom □ Always
Do you experience a physical change in abdominal girth when	
your bowels are full (distension)?	□ Never □ Seldom □ Always
In your opinion, is your fibre intake	□ too low □ adequate □ too high
Do you regularly use	□ laxatives □ stool softeners □ natural products □ enemas

Have you ever been diagnosed with/think you have:

Irritable bowel syndrome When? ________________________ Who? ________________________

Ulcerative colitis When? ________________________ Who? ________________________

Crohn's Disease When? ________________________ Who? ________________________

Celiac Disease When? ________________________ Who? ________________________

Sexual history;

Last PSA score: _________ When? ______________ Last digital rectal exam? ______________

Does your prostate get painful/irritated? o Yes o No

PATIENT NAME: ____________________________ DOB:________________ DATE:_______________

Has your prostate fluid been expressed and tested? o Yes o No
Do you have painful erections? o Yes o No
Can you achieve a satisfactory erection? o Yes o No
Do you have premature ejaculation? o Yes o No
Do you have pain during intercourse? o Yes o No When? _________________

Medical History:

Urinary tract infections	□ Yes □ No	How often?
Antibiotics recently?	□ Yes □ No	Last UTI?
Probiotics?	□ Yes □ No	Cranberry supplementation? □ Yes □ No
Smoker	□ Yes □ No	# ______ packs/day
Chronic cough? □ Yes □ No		
Do you exercise? □ Yes □ No	Type:	Frequency:
Do you get blood in your urine?	□ Yes □ No	
Allergies (including latex):	□ Yes □ No	
Low back problems	□ Yes □ No	Chronic? □ Yes □ No
Mid back problems	□ Yes □ No	Chronic? □ Yes □ No
Neck problems	□ Yes □ No	Chronic? □ Yes □ No
Have you ever been treated for depression?	□ Yes □ No	What treatment?
Have you ever been treated for anxiety?	□ Yes □ No	Whar treatment?

On a scale from 1-10, please circle and rate how much this problem bothers you:

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, please circle and rate how motivated you are to correct this problem

1 2 3 4 5 6 7 8 9 10

PATIENT NAME: ____________________________ DOB:________________ DATE:_______________

DASS Questionnaire

Please read each statement and circle a number, 0, 1, 2, or 3, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

S = _____ A = _____ D = _____

0 = It did not apply to me at all

1 = Applied to me to some degree or some of the time

2 = Applied to me a considerable degree, or a good part of the time

3 = Applied to me very much, or most of the time

I find it hard to wind down……………………………………………………………………………… S 0 1 2 3

I was aware of dryness of my mouth………………………………………………………………. A 0 1 2 3

I could not seem to experience any feeling at all…………………………………………… D 0 1 2 3

I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion…………………………………………………………………… A 0 1 2 3

I found it difficult to work up the initiative to do things………………………………… D 0 1 2 3

I tended to over-react to situations…………………………………………………………….. S 0 1 2 3

I experienced trembling (e.g. hands)…………………………………………………………… A 0 1 2 3

I felt that I was using a lot of nervous energy……………………………………………… S 0 1 2 3

I was worried about situations in which I might panic and make a fool of myself….. A 0 1 2 3

I felt that I had nothing to look forward to………………………………………………….. D 0 1 2 3

I found myself getting agitated…………………………………………………………………… S 0 1 2 3

I found it difficult to relax…………………………………………………………………………… S 0 1 2 3

I felt down-hearted and blue……………………………………………………………………… D 0 1 2 3

I was intolerant of anything that kept me from getting on with what I was doing…. S 0 1 2 3

I felt I was close to panic……………………………………………………………………………. A 0 1 2 3

PATIENT NAME: ___________________________ DOB:________________ DATE:_______________

I was unable to become enthusiastic about anything………………………………………………. D 0 1 2 3
I felt I was not much of a person……………………………………………………………………. D 0 1 2 3
I felt that I was rather touchy……………………………………………………………………… S 0 1 2 3
I was aware of the action of my heart in the absence of physical exertion
(e.g. sense of heart rate increase, heart missing a beat)……………………………………… A 0 1 2 3
I felt scared without any good reason……………………………………………………………. A 0 1 2 3
I felt that life was meaningless……………………………………………………………………. D 0 1 2 3