

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

## **Male Symptom Monitor**

Occupation

\_\_\_\_\_

Presenting  
problems

\_\_\_\_\_

\_\_\_\_\_

When did this start? \_\_\_\_\_

***Please fill out each section that is relevant to your problem***

**Have you had any of the following medical procedures? If so, please provide approximate date:**

Appendectomy \_\_\_\_\_ Hernia repair \_\_\_\_\_ Vasectomy \_\_\_\_\_

Hemorrhoid banding \_\_\_\_\_ Prostatectomy \_\_\_\_\_ Cystoscopy \_\_\_\_\_

Urodynamics \_\_\_\_\_ Gallbladder removal \_\_\_\_\_ Bowel resection \_\_\_\_\_

Colostomy \_\_\_\_\_ Other \_\_\_\_\_

### **Bladder Symptoms**

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 stream?  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

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Do your bladder problems cause you to leak at night?  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

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 # \_\_\_\_\_ alcoholic drinks/day

### Digestion & Bowel Function

What is the frequency of your bowel movements? \_\_\_\_\_

Do you feel the urge to move your bowels?  Never  Seldom  Never

Do you have constipation?  Always  Seldom  Never

Do you strain to have a bowel movement?  Always  Seldom  Never

Do you have loose stools/diarrhea?  Always  Seldom  Never

Do you have bowel urgency that is difficult to control?  Always  Seldom  Never

Do you lose control of your bowels?  Always  Seldom  Never

Do you have incomplete emptying?  Always  Seldom  Never

Do you have pain with a bowel movement?  Always  Seldom  Never

Do you have pain after a bowel movement?  Always  Seldom  Never

Does it take longer than 5 minutes to have a bowel movement?  Always  Seldom  Never

Do you have bloating? (increased pressure in abdomen)  Always  Seldom  Never

Do you experience a physical change in abdominal girth when your bowels are full (distension)?  Always  Seldom  Never

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? \_\_\_\_\_

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Do you have any food allergies or sensitivities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History**

Urinary tract infections  Yes  No How often? \_\_\_\_\_

Antibiotics recently?  Yes  No Last UTI? \_\_\_\_\_

Probiotics?  No  Yes Cranberry supplementation?  No  Yes

Smoking  Yes  No # \_\_\_\_\_ packs/day Chronic cough  Yes  No

Do you get blood in your urine?  Yes  No

Allergies (including latex): \_\_\_\_\_

Do you exercise?  No  Yes Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

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? \_\_\_\_\_

Is/was treatment effective?  No  Yes

Have you ever been treated for anxiety?  Yes  No What treatment? \_\_\_\_\_

Is/was treatment effective?  No  Yes

**Sexual history**

Last PSA score: \_\_\_\_\_ When? \_\_\_\_\_ Last digital rectal exam? \_\_\_\_\_

Does your prostate get painful/irritated?  Yes  No Has your prostate fluid been expressed and tested?  Yes  No

Do you have painful erections?  Yes  No Can you achieve a satisfactory erection?  No  Yes

Do you have premature ejaculation?  Yes  No

Do you have pain during intercourse?  Yes  No When? \_\_\_\_\_

***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

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## DASS Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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
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