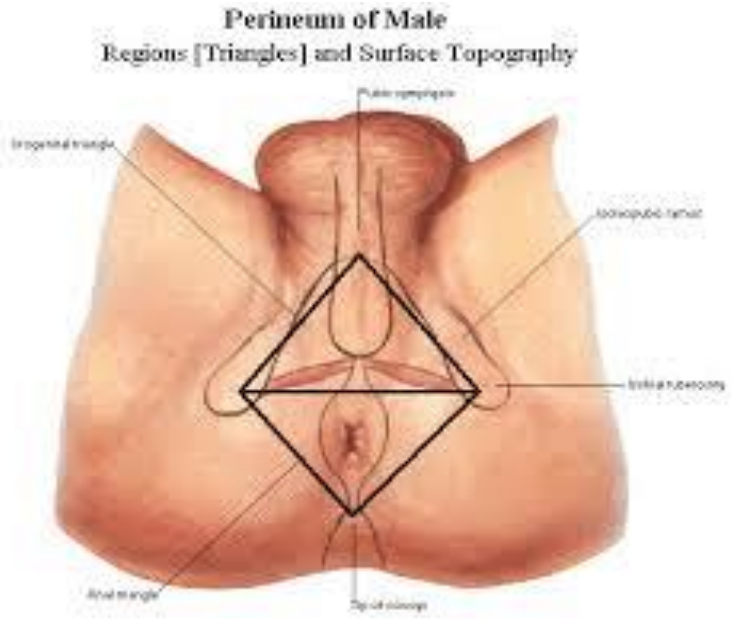
Male Intake Form

Name:_____ Date:_____

DOB: _____

(Please only complete what is applicable to your symptoms, otherwise put N/A).

Please mark If you are Having pain (x) or tingling (-) in areas on this diagram



1. On a scale of 0-10 (0= no pain and 10 = emergency room pain) how much pain do you have

   Current level? _____

   When it's at the worst? _____

   When it's at the best? _____

2. When did your symptoms start? _____
3. What do you think caused your symptoms? _____

4. Have you been seen by other medical professionals for these symptoms? If so, so who and did they find a diagnosis or cause?

   _____

5. Have you had surgery that directly relates to your current symptoms? If so, what type and when?

   _____

6. Out of 0-10 (0=no effect and 10 severe impairment), how much is your problem affecting your quality of life? _____
7. Please answer the following questions regarding URINARY symptoms if applicable:

   a. Do you have difficulty initiating your stream? _____

   b. Is the stream weak or interrupted? _____

   c. How many times a day do you void? _____

   d. How many times do you wake up at night to void? _____

   e. Do you experience any pain before, during, or after voiding? _____

   f. Any behaviors that aggravate the urinary symptoms?

   _____

   g. Does anything (positions, diet, etc.) improve your urinary symptoms?_____
8. Please answer these questions regarding your BOWEL habits:

   a. Do you have a history of constipation? _____

   b. How often do you have a bowel movement? _____

   c. Do you experience pain before, after or during a bowel movement? _____

   d. Do you have anal fissures or hemorrhoids? _____

9. Please answer the following questions regarding SEXUAL functioning:

   a. Are you able to have an erection? _____

   b. Are you able to ejaculate? _____

   c. Do you experience pain, urinary, or bowel symptoms during or after ejaculation? _____