



# Men's Pelvic Health Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Describe the reason for today's appointment (main complaint/problem): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What goals do you hope to accomplish with therapy? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When did the problem begin? \_\_\_\_\_ Is it better, worse, or staying the same? \_\_\_\_\_

Have you had any prior treatment for this problem? YES / NO If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List activities or things that you cannot do because of this problem. How does the problem affect your life? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What are you currently doing to manage the problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Medical History:** \*Please check any that you have had or currently have\*

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Childhood illnesses           | <input type="checkbox"/> Back problems       | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Heart problems                | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Serious injury     |
| <input type="checkbox"/> Lung disease                  | <input type="checkbox"/> Chronic cough       | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Car accident       |
| <input type="checkbox"/> Kidney disease                | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Glaucoma           |
| <input type="checkbox"/> Urinary Tract Infections      | <input type="checkbox"/> Emotional problems  | <input type="checkbox"/> Bowel problems       | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Liver disease                 | <input type="checkbox"/> Seizure disorder    | <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Neurologic Disease |
| <input type="checkbox"/> Other (please specify): _____ |  |   |   |

**Allergies:** Do you have any allergies? YES / NO If yes, please list what you are allergic to and the reaction you have had: \_\_\_\_\_  
\_\_\_\_\_

**Medications:** Please list all of your current medications (include dosage & frequency taken): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgical History:** Have you ever had any operations? YES / NO If yes, please list the TYPE of surgery, the REASON, and the DATE of surgery: \_\_\_\_\_  
\_\_\_\_\_

**Health Habits:**

Do you see a doctor regularly for exams? YES / NO

Do you exercise regularly? YES / NO If yes, what type of exercise & how often? \_\_\_\_\_  
\_\_\_\_\_

Do you have any physical limitations? YES / NO If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Emotional History:**

Does emotional stress affect your symptoms? YES / NO

Have you ever been diagnosed with and/or treated for a nervous condition? YES / NO

Have you ever been diagnosed with and/or treated for depression? YES / NO

Have you ever experienced domestic violence? YES / NO

Have you ever experienced rape? YES / NO Date rape? YES / NO

Have you ever experienced sexual abuse/molestation? YES / NO

**Symptom Severity:**

On a scale of 0 – 10 with 10 being the most severe, what is the current severity of your problem? \_\_\_\_\_

With 0 being not true at all and 10 being true, rate the following statement as it applies to you today:

“My problem is controlling my life” Rating: \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING SECTIONS THAT ARE APPLICABLE TO YOUR PROBLEM.**

**FOR ANY PAIN QUESTIONS, PLEASE REFER TO THIS MANKOSKI PAIN SCALE:**

**0** – Pain free

**1** – Very minor annoyance with occasional minor twinges. No medication needed.

**2** – Minor annoyance with occasional strong twinges. No medication needed.

**3** – Annoying enough to be distracting. Mild painkillers (such as aspirin or ibuprofen) to take care of pain.

**4** – Can be ignored if you are really involved in your work but still distracting. Mild painkillers remove the pain for 3-4 hours.

**5** – Can't be ignored for more than 30 minutes. Mild painkillers make the pain better or more tolerable for 3-4 hours.

**6** – Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (such as codeine or narcotics) reduce pain for 3-4 hours.

**7** – Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective.

**8** – Physical activity severely limited, you can read and converse with effort. Nausea and dizziness set in as factors of pain.

**9** – Unable to speak, crying out or moaning uncontrollably – near delirium.

**10** – Unconscious, pain makes you pass out.

**Section A: Pelvic/Back Pain**

Do you experience pelvic pain? YES / NO (If no, skip to section B)

If yes, give a description and location of the pain: \_\_\_\_\_

Do you experience pain with intercourse? YES / NO

If yes, \*please check\* all that cause pain and rate the severity 1-10:

- Arousal - \_\_\_/10                       Thrusting - \_\_\_/10                       Orgasm - \_\_\_/10  
 Other: \_\_\_\_\_ - \_\_\_/10

Does the pain continue after intercourse? YES / NO    If yes, pain rating \_\_\_/10

How long does the pain last? \_\_\_\_\_ hours or \_\_\_\_\_ days

Mark any of the following events that cause pain and rate the severity 1-10:

- During rectal exam - \_\_\_/10                       Certain clothing - \_\_\_/10                       Sitting - \_\_\_/10  
 Other: \_\_\_\_\_ - \_\_\_/10

Do you experience back pain? YES / NO    If yes, please rate: \_\_\_/10 and describe: \_\_\_\_\_

How long have you had this pelvic/back pain? \_\_\_\_\_

Any event (such as accident or surgery) associated with the onset of your pelvic/back pain and symptoms? YES / NO    If yes, please explain: \_\_\_\_\_

## Section B: Voiding Habits

Did you have difficulty holding urine as a child? YES / NO

As a child, did you wet the bed beyond the age of 5? YES / NO

Have you been treated for more than two urinary tract infections this year? YES / NO

When was the last time you had a urinary tract infection? \_\_\_\_\_

Is your urine ever bloody? YES / NO

Have you ever been treated with urethral dilation? YES / NO

If yes, how many times? \_\_\_\_\_ Did it help? YES / NO

Do you feel that you urinate too often? YES / NO

Do you usually get up to urinate during sleeping hours? YES / NO If yes, how many times? \_\_\_\_\_

How often do you pass urine during the day? Every \_\_\_\_\_ hours

Is the volume of urine you usually pass: \_\_\_Very small \_\_\_Small \_\_\_Average \_\_\_Large

Do you restrict your fluid intake because of your problem? YES / NO

Do you constantly feel an urge to urinate? YES / NO

Do you often experience a strong, sudden urge to urinate? YES / NO

Do you often feel you must rush to the toilet? YES / NO

How long can you hold back the urge to urinate? \_\_\_\_\_

Do you lose urine when you have the urge to urinate? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

Do you experience a strong sense of urgency with any of the following: \*Please check all that apply\*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Temperature changes    | <input type="checkbox"/> Running water | <input type="checkbox"/> Entering the house |
| <input type="checkbox"/> Approaching the toilet | <input type="checkbox"/> Other: _____  |   |

Do you sometimes feel you need to urinate again immediately after urinating? YES / NO

Do you void before leaving the house "just in case"? YES / NO

Do you have difficulty emptying your bladder completely? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

How do you manage this problem? \_\_\_\_\_

Is the urine stream ever hesitant or interrupted? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

Do you need to strain to empty? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

Do you have difficulty telling when your bladder is full? YES / NO

Do you dribble just after urinating (when you stand up)? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

Do you have trouble stopping your urine midstream? YES / NO

## Section C: Urinary Incontinence

Do you experience uncontrollable loss of urine? YES / NO (If no, skip to Section D)

Do you lose urine with any of the following events: \*Please check all that apply\*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Coughing           | <input type="checkbox"/> Sneezing          | <input type="checkbox"/> Lifting objects |
| <input type="checkbox"/> Straining          | <input type="checkbox"/> Bending           | <input type="checkbox"/> Walking         |
| <input type="checkbox"/> During intercourse | <input type="checkbox"/> After intercourse | <input type="checkbox"/> Other: _____    |

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**Section C: Urinary Incontinence (continued)**

Is the volume you lose: \_\_\_A few drops \_\_\_Wet underwear or pad \_\_\_Soaked pad or clothing

Do you lose urine with a strong urge that cannot be controlled? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

In which positions does urine loss usually occur?

- Lying Down
- Sitting
- Standing
- Moving from sitting to standing position
- Moving from standing to sitting position

Is your loss of urine a continual drip so that you feel constantly wet? YES / NO

Do you ever lose urine without any warning or urge? YES / NO If yes, please explain when/how: \_\_\_\_\_

Do you lose urine without feeling it happen? YES / NO

Do you wear protection for urine loss? YES / NO If yes, what type? \_\_\_\_\_

Do you experience hygiene or skin problems related to your leakage? YES / NO

Do you have discomfort associated with your bladder? YES / NO

If yes, location/description of pain: \_\_\_\_\_

**Section E: Bowel Habits**

How often do you have a bowel movement? \_\_\_\_\_

Do you ever attempt evacuation without results? YES / NO If yes, how often? \_\_\_\_\_

Do you use any of the following to help you evacuate? \*Please check all that apply\*

- Suppository
- Enema
- Fiber supplement
- Manual removal
- Laxatives (Type: \_\_\_\_\_)
- Other: \_\_\_\_\_

Do you ever experience blood in the stool or on the tissue? YES / NO

What sensation do you experience when you need to evacuate?

\_\_\_Normal \_\_\_Blunted/uncertain \_\_\_Strong/urgent

Do you constantly feel an urge to evacuate? YES / NO

Do you lose stool with a strong urge that cannot be controlled? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

How long can you hold the urge to evacuate? \_\_\_\_\_

Do you have a problem with constipation? YES / NO

Do you strain to pass stool? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

On average, how much time do you spend on the toilet for each evacuation? \_\_\_\_\_

Do you have difficulty emptying your bowels completely? YES / NO If yes, when does it occur?

\_\_\_All of the time \_\_\_Most of the time \_\_\_Half of the time \_\_\_Some of the time

Where do you feel stool remains? \_\_\_At the anal opening or \_\_\_Higher in the rectum/colon

Do you have difficulty with hygiene after a bowel movement? YES / NO

Are you unable to feel the difference between solid stool, liquid stool, and gas? YES / NO

**Section F: Bowel Incontinence**

Are you unable to avoid passing gas in public? YES / NO

Do you experience uncontrollable loss of stool or stool seepage? YES / NO (If no, skip to Section G)

Do you lose stool with any of the following events? \*Please check all that apply\*

- Coughing
- Sneezing
- Lifting
- Straining
- Releasing gas
- Urinating
- Aerobic exercise
- Intercourse
- Other: \_\_\_\_\_

Is the amount you lose:

\_\_\_ Stain/smear \_\_\_ 2tbsp or less \_\_\_ 1/4 to 1/2 cup \_\_\_ 1/2 to 1 cup \_\_\_ Greater than 1 cup

How often does this happen? \_\_\_\_\_

What is the consistency of the stool you lose?

- Formed/solid
- Hard balls
- Loose/unformed
- Liquid/mucous

Do you lose stool with a strong urge that cannot be controlled? YES / NO If yes, when does it occur?

\_\_\_ All of the time \_\_\_ Most of the time \_\_\_ Half of the time \_\_\_ Some of the time

Do you ever lose stool without any warning or urge? YES / NO If yes, please explain when/how: \_\_\_\_\_

Do you lose stool without feeling it happen? YES / NO If yes, please explain when/how: \_\_\_\_\_

Does the stool loss, seepage, or straining occur after a bowel movement? YES / NO

Does the stool loss, seepage, or straining occur during sleep? YES / NO

Do you wear protection for urine loss? YES / NO If yes, what type? \_\_\_\_\_

**Section G: Bowel/Abdominal Pain**

Do you experience pain related to bowel function? YES / NO (If no, you have completed this form!)

If yes, location/description of the pain: \_\_\_\_\_

Mark any of the following events that cause pain and rate the severity:

- Before bowel movement - \_\_\_/10
- During bowel movement - \_\_\_/10
- After bowel movement - \_\_\_/10
- With meals - \_\_\_/10
- Other: \_\_\_\_\_ - \_\_\_/10

How long have you had this bowel/abdominal pain? \_\_\_\_\_

Any event (such as an accident or surgery) associated with the onset of your bowel/abdominal pain symptoms? YES / NO If yes, please explain: \_\_\_\_\_

**You have completed this form!**