

MALE QUESTIONNAIRE

Name: _____ Age: _____ Date of Birth: _____

Date of your last Prostate exam: _____ Who is your Urologist? _____

When was the last time you saw your Urologist? _____ Do you have a history of Prostate Cancer? Yes No Last PSA Level? _____

REVIEW OF SYMPTOMS – Please check the box next to any symptoms that you have been experiencing

GENERAL	<input type="checkbox"/> Loss of energy / weakness <input type="checkbox"/> Decreased flexibility <input type="checkbox"/> Stress	<input type="checkbox"/> Fatigue / tiredness <input type="checkbox"/> Weight gain in breast/hips/waist	<input type="checkbox"/> Loss of Fitness <input type="checkbox"/> Adult Mumps <input type="checkbox"/> Rapid aging	<input type="checkbox"/> Burned out feeling <input type="checkbox"/> Decreased stamina
SKIN	<input type="checkbox"/> Wrinkles <input type="checkbox"/> Brittle nails <input type="checkbox"/> Rashes	<input type="checkbox"/> Dry skin / Dry hair <input type="checkbox"/> Thinning skin <input type="checkbox"/> Itching	<input type="checkbox"/> Morning and evening fatigue <input type="checkbox"/> Oily skin <input type="checkbox"/> Lesions	<input type="checkbox"/> Hypothermia <input type="checkbox"/> Acne
HEAD	<input type="checkbox"/> Trauma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Tenderness	
EYES	<input type="checkbox"/> Swelling/Puffiness <input type="checkbox"/> Discharge	<input type="checkbox"/> Change in visual field <input type="checkbox"/> Inflammation	<input type="checkbox"/> Sensitivity to light <input type="checkbox"/> Use of glasses	<input type="checkbox"/> Double Vision
EARS	<input type="checkbox"/> Ringing in ears <input type="checkbox"/> Discharge	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hearing Changes	<input type="checkbox"/> Pain
NOSE	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Obstructive polyps	<input type="checkbox"/> Deviated septum
THROAT	<input type="checkbox"/> Goiter <input type="checkbox"/> Lesions	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Discharge	<input type="checkbox"/> Dentures	<input type="checkbox"/> Inflammation
RESPIRATORY	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing up blood
CARDIOVASCULAR	<input type="checkbox"/> Hypertension <input type="checkbox"/> Bradycardia <input type="checkbox"/> Murmurs	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitations <input type="checkbox"/> Short of Breath	<input type="checkbox"/> Tachycardia <input type="checkbox"/> Rheumatic fever
GASTROINTESTINAL	<input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Decreased Appetite <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Constipation	<input type="checkbox"/> Problem Swallowing <input type="checkbox"/> Indigestion <input type="checkbox"/> Black Stool	<input type="checkbox"/> Nausea <input type="checkbox"/> Pain <input type="checkbox"/> Hemorrhoid
GENITOURINARY (BOTH)	<input type="checkbox"/> Loss of libido or sex drive <input type="checkbox"/> Frequency <input type="checkbox"/> Nocturia	<input type="checkbox"/> Delayed orgasm or decreased intensity <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinence	<input type="checkbox"/> Discomfort during sex <input type="checkbox"/> Dysuria	<input type="checkbox"/> Infertility problems <input type="checkbox"/> Hematuria
GENITOURINARY (MALE)	<input type="checkbox"/> Erection Problems <input type="checkbox"/> Vasectomy	<input type="checkbox"/> Loss of morning erection <input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Orchitis/testicular problems <input type="checkbox"/> Loss of facial hair	<input type="checkbox"/> Prostate problems/operation
ENDOCRINE	<input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Excessive Urinating	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Decreased sweating <input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Hair loss/thinning/oily <input type="checkbox"/> Problem Swallowing <input type="checkbox"/> Hormone Therapy	<input type="checkbox"/> Crave Sugar <input type="checkbox"/> Increased Thirst
SKELETOMUSCULAR	<input type="checkbox"/> Arthritis <input type="checkbox"/> Decreased flexibility	<input type="checkbox"/> Backache/Joint pain/Stiffness <input type="checkbox"/> Neck/Back pain	<input type="checkbox"/> Decreased muscle size <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Sore muscles
HEMATOLOGY	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Easy bruising	

NEUROLOGICAL	<input type="checkbox"/> Loss of memory/concentration <input type="checkbox"/> Decreased mental sharpness	<input type="checkbox"/> Dizziness <input type="checkbox"/> Mental fatigue <input type="checkbox"/> Seizures	<input type="checkbox"/> Headaches/migraines <input type="checkbox"/> Numbness hands/feet <input type="checkbox"/> Weakness	<input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Vertigo <input type="checkbox"/> Coordination problems
PSYCHIATRIC	<input type="checkbox"/> Anxiety and/or nervousness <input type="checkbox"/> Tearfulness	<input type="checkbox"/> Depression <input type="checkbox"/> Mood swings	<input type="checkbox"/> Low or negative mood <input type="checkbox"/> Apathy	<input type="checkbox"/> Irritability or bad temper <input type="checkbox"/> Aggressive behavior
RENAL	<input type="checkbox"/> Fluid retention			

PATIENT HISTORY	NO	YES - EXPLAIN	PATIENT HISTORY	NO	YES - EXPLAIN
Heart Disease			Blood Clotting Problems		
High Cholesterol			Diabetes		
High Blood Pressure			Arthritis/Joint Problems		
Cancer			Depression		
Ulcers			Epilepsy		
Thyroid Disease			Headaches/Migraines		
Hormonal Related Issues			Eye Disease		
Lung Conditions			HIV		
Hepatitis A, B or C			Lupus		
Chronic Fatigue Syndrome			Liver Condition		
Fibromyalgia			Other		
ALLERGIES: Medications			ALLERGIES: Foods		
ALLERGIES: Other					

What are your expectations from our services? _____

Please list any questions you may have:

Patient Signature: _____ Date: _____