BIHC | Belleville Integrative Health Centre
WORKING TOGETHER FOR YOUR HEALTH

MALE SYMPTOM MONITOR

Name: _____ Date: _____

Occupation: _____ Age: _____

Complaints: 1. _____

2. _____

3. _____

SURGICAL HISTORY:

Abdominal: ☐ When: _____

Pelvic: ☐ When: _____

BLADDER SYMPTOMS: Please put an X next to the statements that best describe your symptoms:

My incontinence is associated with activities such as sneezing, running or coughing ☐ daily ☐ weekly

S

My incontinence is preceded by a strong sensation that feels uncontrollable ☐ daily ☐ weekly

U

My incontinence is associated with frequency of urination during the day (>5-7 X/day)___ ____ # times per day

F

My bladder troubles cause frequent nighttime urination _____ # times/night

N

My incontinence is associated with frequent nighttime bedwetting _____ # times/week

My incontinence requires me to wear pads _____ # pads/day

My bladder troubles include incomplete emptying ☐ Yes ☐ No ☐ Sometimes

R

I have pain when I urinate ☐ Yes ☐ No ☐ Sometimes

I have to strain when I urinate ☐ Yes ☐ No ☐ Sometimes

TP

I have leakage during intercourse ☐ Yes ☐ No ☐ Sometimes

I had problems with urination during my childhood ☐ Yes ☐ No

Urinary Urgency without urine loss ☐ Yes ☐ No

Fluid Intake in 24 hours:

#____cups of coffee/day #____cups of water/day #____cups of tea/day # _____ cups of other fluids/day

Pelvic Health Solutions
Restoring Pelvic Health through Physiotherapy

BIHC | Belleville Integrative Health Centre
WORKING TOGETHER FOR YOUR HEALTH

BOWEL HISTORY:

Frequency: /week

Fecal Incontinence: ☐ Yes ☐ No Stool Consistency:
☐ Loose ☐ Soft/formed ☐ Hard ☐ Varies

Fecal Urgency: ☐ Yes ☐ No

Constipation: ☐ Yes ☐ No

MEDICAL HISTORY:

Urinary Tract Infections: ☐ Yes ☐ No Antibiotics Recently? ☐ Yes ☐ No

Smoking: ☐ Yes ☐ No ____ #packs/day

Chronic Cough: ☐ Yes ☐ No

Do you get blood in your urine: ☐ Yes ☐ No

Allergies (including latex): _____

Height: ____ ft. ____ In. Weight: _____ lbs BMI: _____(therapist)

Back Problems: ☐ Yes ☐ No
If yes, please ask the receptionist for the Pelvic Girdle Pain Assessment

Neck Problems: ☐ Yes ☐ No Chronic? ☐ Yes ☐ No

Have you ever been treated for depression? ☐ Yes ☐ No

SEXUAL HISTORY:

Last PSA Score: _____ When? _____

Last digital rectal exam? _____

Prostate Fluid expressed and tested? ☐ Yes ☐ No

Do you have painful erections? ☐ Yes ☐ No

Can you achieve a satisfactory erection? ☐ Yes ☐ No

Do you have premature ejaculation? ☐ Yes ☐ No

Do you have pain during intercourse? ☐ Yes ☐ No

On a scale from 1-10, please circle and rate your current pain/discomfort

1 2 3 4 5 6 7 8 9 10