Amir Saffarian, M.D. Inc

MALE PATIENT QUESTIONNAIRE:

Name ________________________________ Date_________________________

Age ___________ Family Physician __________________________

Reason for Visit - ______________________________

____

____

Urinary Symptoms	Yes	No
Does your urination start immediately?	____	____
Is your urinary stream slow?	____	____
Do you have significant urgency with urination?	____	____
Do you awaken at night to urinate?	____	____
If yes, how many times?	____	
Do you push or strain with urination?	____	____
When you finish urinating, do you feel empty?	____	____
Does it burn or sting when you urinate?	____	____
How many times do you urinate during the day?	____	
Do you leak urine with straining or coughing?	____	____
Do you leak urine while trying to reach bathroom?	____	____
If yes to either of the above, do you use pads?	____	____
If yes, how many?	____	
Have you ever seen an urologist before?	____	____
If yes, why and what was done?	______________________________	

____

Urinary Tract Infections	Yes	No
Have you ever had a prior urinary tract infection	____	____
If yes, how many?	______________	
Age infections started ?	______________	
Last infection?	______________	
Have you ever had a prostate or kidney infection?	____	____
Have you ever had a fever with infection?	____	____
Have you ever had pain in the back with infection?	____	____
Have you ever had X-rays of the kidney?	____	____
Were you ever hospitalized to treat an infection?	____	____
Have you ever had a sexually transmitted disease?	____	____

I have reviewed the contents of this history in its entirety. ________MD Date ________

Kidney Stones **Yes** **No**

Do you have any pain in the back or abdomen? ____ ____

Have you ever had a kidney stone before? ____ ____

If yes, when? __________

How many? __________

Passed on own? __________

Surgically removed? __________

What was the stone made of? __________

Did you have a work-up to determine the cause? ____ ____

Any prior dietary changes or medications? ____ ____

If yes, what?____

____

Hematuria **Yes** **No**

Have you ever seen blood in the your urine? ____ ____

If yes, when? __________

How many times? __________

Did you have any pain or burning at the time? ____ ____

Has a doctor ever found blood with a microscope? ____ ____

Have you ever had prior work up for this problem? ____ ____

If yes, when? ________________

What was done? ________________

What was found? ________________

Erectile Dysfunction **Yes** **No**

Do you have a trouble with erections? ____ ____

If yes- Do you awaken with a good erection? ____ ____

Do you have trouble obtaining an erection? ____ ____

Do you have trouble maintaining an erection?____ ____

Do you have curvature with erections? ____ ____

Is sex an important part of your life? ____ ____

On a scale of 1 to 10 rate the quality of your erections _______

How often are you able to complete sexual intercourse? ______%

Medical History

Medical Illnes **Date Discovered** **Treatment**

1.____

2.____

3.____

4.____

5.____

6.____

Surgical History

Surgery	Date	Disease
1.		
2.		
3.		
4.		

Medications

Name	Dosage	How often (i.e. once or twice a day)

Please make sure to include **DOSAGE** and ANY blood thinners (i.e. aspirin, plavix, coumadin, ibuprofen or herbal medications)

1.____________________
2.____________________
3.____________________
4.____________________

Allergies ☐ No Known Drug Allergies

Name of medication	Reaction
1.	
2.	
3.	
4.	

Family History **(Include High blood pressure, diabetes, cancer etc.)**

(Also include prostate, kidney or bladder cancer or problems)

Family Member	Age	Disease
1.______Father		
2.______Mother		
3.		
4.		

Social History

		Yes	No
Do you or have you ever smoked?		____	____
If yes, how much?	_________packs/day		
How long?	_________		
Have you quit?		____	____
If yes, when?	_________		
Do you drink alcohol?		____	____
If yes, how much?	_________		
How long?	_________		
Are you employed?		____	____
If yes, what type of work?		________________	

Marital status _______ single, _______ married, ______ divorced

Review of Systems	Yes	No	Describe__________
Have you ever had serious problems with: (please circle)			
Constitutional (fevers, chills, headache)	Y	N	
Integumentary (skin rash, itchiness, Boils)	Y	N	
Eyes (blurred vision, Double vision, pain)	Y	N	
Ears, nose and throat (sore throat, ear infection Sinus problems)	Y	N	
Neurologic (tremors, dizzy spells, Numbness/tingling)	Y	N	
Endocrine (tiredness, excessive Thirst, too hot/cold)	Y	N	
Heart (chest pain, heart attack, , high blood pressure.)	Y	N	
Lungs (shortness of breath, TB, asthma cough, wheezing.)	Y	N	
Gastrointestinal (ulcers,hepatitis, abdominal Pain, nausea/vomiting bleeding,ect.)	Y	N	
Hematologic (bleeding, blood clots lymphoma, anemia, ect.)	Y	N	
Psychiatric (depression, mental illness)	Y	N	
Musculoskeletal (arthritis, disc disease, ect.)	Y	N	

	0 Not at all	**1** Less than 1 in 5	**2** Less than half the time	**3** About half the time	**4** More than half the time	**5** Almost always
Over the past month, how often have you had the sensation of not completely emptying your bladder after urinating?						
Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?						
Over the past month, how often have you stopped and started several times during urination?						
Over the past month, how often have you found it difficult to postpone urination?						
Over the past month, how often have you had a weak urinary stream?						
Over the past month, how often have you had to push or strain to begin urination?						
During the night, how many times do you get up to urinate?	None	1 time	2 times	3 times	4 times	5 times or more

Score results: mild 0-7 moderate 8-19 severe 20-35

Total symptom score _______

BLADDER SATISFACTION SURVEY

Which symptoms best describe you?

Frequent Urination – Day, Night, or Both
Sudden or Strong Urge to urinate
Unable to Empty the Bladder
Leaking with Sneezing, Coughing, Exercising
Leaking with Urge or No Warning
(Unable to make it to the bathroom in time)
Bladder or Pelvic Pain

How long have you had these symptoms? ____________________

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

Detrol® LA Ditropan XL® Flomax® Cardura® Gelnique®

Oxytrol® Patch Enablex® VESIcare® DDAVP® Toviaz®

Sanctura® Elavil® Elmiron® Other______________

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

If you've stopped taking your meds explain why:
Did not Help Side Effects Too Expensive

Describe Side Effects ____

Behavior Modifications Tried____________________________________
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated **Very Frustrated**

Do you currently have any problems with bowel function?:
Fecal Incontinence Constipation Other

I am interested in learning more about treatment alternatives to medications:
Yes No

BOWEL CONTROL SATISFACTION SURVEY

Which symptoms best describe you?

- Bowel accidents because I am unable to make it to the bathroom in time
- Bowel accidents while asleep/unaware
- Frequent loose/watery stool
- Abdominal pain

How long have you had these symptoms? ________________

Approximately how many bowel accidents do you have per week? ______________

Behavior modifications tried ____
(i.e. lifestyle changes, fiber, diet changes, pelvic floor muscle training/biofeedback)

Have you tried medications to help you symptoms? Yes No
If yes, please specify:

Imodium	Lomotil
Imotil	Diphenoxylate
Loperamide	Other ________________

Did these medications help your symptoms? Circle #
0 1 2 3 4 5 6 7 8 9 10
No Relief *Completely Cured*

If you've stopped taking your meds, explain why:

Any side effects? _____________________________________

What is your level of frustration with your bowel control symptoms? Circle #
0 1 2 3 4 5 6 7 8 9 10
Not Frustrated *Very Frustrated*

I am interested in learning more about other treatment options: Yes No