Florida Hospital PELVIC HEALTH REHABILITATION

MALE INTAKE FORM

Name: ____ DOB: _____________ Date: ______________

1. What do you think caused your symptoms?

2. How many physicians have you seen regarding this problem?

3. Have you had a surgery that directly relates to your current symptoms?

4. Out of 0-10 (0 = no effect and 10 = severe impairment), how much is your problem affecting your quality of life?

5. When did your symptoms start?

6. Please answer the following questions regarding your **URINARY** symptoms:
   - Do you have difficulty initiating your stream (urinary hesitancy)?
   - Do you have urinary leakage?
     - If so, how many times per day?
     - If so, how many pads (at most) per day?
   - Is the stream weak and/or interrupted?
   - How many times a day do you void?
   - How many times do you wake up at night to void?
   - Do you experience pain before, during, or after voiding?
   - Do any behaviors aggravate your urinary symptoms?
   - Does anything (positions, diet, etc.) improve your urinary symptoms?

7. Please answer the following questions regarding your **<u>BOWEL</u>** habits:
   - Do you have a history of constipation?
   - Do you have any fecal leakage?
     - If so, how are you managing (pads, etc.)?
   - How often do you have a bowel movement?
     - Per Day?
     - Per Week?
   - What is consistency of your bowel movement (hard, soft)?
   - Do you experience pain before, during, or after a bowel movement?
   - Do you have anal fissures of hemorrhoids?
   - Does anything make your bowels better or worse?
   - Are you currently taking anything (i.e. stool softeners, laxatives)?
   - What is your daily fluid intake?
   - Have you made any dietary changes?

8. Please answer the following questions regarding **<u>SEXUAL</u>** functioning:
   - Are you able to obtain an erection?
   - Are you able to ejaculate?
   - Do you experience pain or urinary or bowel symptoms during or after ejaculation?