PATIENT QUESTIONNAIRE: MALE PELVIC FLOOR

Name: _____ **Age:** _____ **DOB:** _____

Referring Doctor: _____ **Diagnosis:** _____

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date):_____

Have you received other treatment for this problem? No OR Yes: (type)_____

Medical History (circle all that apply): heart problems / hypertension / diabetes / cancer / seizures thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis rheumatoid arthritis / hx of stroke / kidney problems / depression / osteoporosis / hx of blood clots/DVTs

Other:_____

Surgical History (list type & date): _____

_____

Pelvic History (fill in blanks or circle answer for all that apply):

History of Benign Prostatic Hyperplasia? No OR Yes: (specify date(s) and any treatments received)

_____

History of prostate cancer? No OR Yes: (specify date(s) and treatments) _____

_____

History of hemorrhoids or other colorectal problems? No OR Yes: (specify date(s) and treatments)

_____

History of sexually transmitted diseases: No OR Yes: (specify active infections)_____

History of chronic urinary / bladder infections? No OR Yes: (specify)_____

Current Medications: _____

Allergies: _____

Work Status: ☐ currently working ☐ retired ☐ temporarily off work ☐ unemployed ☐ other:

Location / type of work: _____

Emergency Contact:

Name: _____ Daytime phone #: (____)_____ -_____

How did you learn about us? ☐ friend ☐ physician ☐ internet ☐ advertisement ☐ other:

Date of your next doctor's appointment: _____

_____ _____

Patient's Signature **Date**

MALE PELVIC FLOOR REHAB: SYMPTOM QUESTIONNAIRE

Urinary Symptoms: Check all that apply and fill in appropriate blanks.

___ Urgency (experiencing unusually strong urges to urinate that may come on suddenly)
___ Frequency: urinate _____ times per (circle one) hour / day.
___ Leaking: When I leak, it (circle all that apply):
dampens underwear / dampens outerwear / empties my bladder completely.
___ Leaking: I leak with (circle all that apply): a strong urge to urinate / lifting / coughing laughing / sneezing / bending / standing up / opening door to house / parking car on way to bathroom / walking / jogging/exercise / hear running water / dribble after urination other:_____
___ Leaking: I leak _____ times a (circle one): day / week.
___ Leaking: I cannot tell when I leak; sometimes it feels like I constantly leak.
___ Use of leakage protection (number per day): thin liner____ / pad____ / diaper_____
___ Wake at night to urinate: number of times each night: _____
___ Burning with urination
___ Abnormal stream (specify:_____)
___ Difficulty or hesitancy with emptying bladder

Other:_____

Fluid Intake: Fill in average number of cups (1 cup=8 ounces) of intake of each of the following per day:

___ Water ____ Milk ____ Juice (specify:_____)
___ Soft Drinks ____ Decaf Soft Drinks ____ Tea
___ Decaf Tea ____ Coffee ____ Decaf Coffee
___ Alcohol ____ Other:_____

Bowel Symptoms: Check all that apply and fill in blanks.

Number of bowel movements per (circle one) day / week : _____

___ Constipation: Do you frequently strain to move bowels because of this? Yes OR No
___ Take regular fiber supplements (type and frequency):_____
___ Frequent diarrhea
___ Irritable bowel syndrome
___ Lactose intolerance or other food allergy affecting bowels (specify other: _____)
___ Bowel leakage (circle all that apply): stains underwear / small amount / large amount
I leak with lifting / coughing / laughing / sneezing / bending / standing up / walking / jogging/exercise / sexual intercourse / other:_____
___ Bowel leakage: I leak _____ times a (circle one) day / week.
___ Use of leakage protection (number per day): panty liner____ / pad____ / diaper_____

Pelvic History (fill in blanks or circle answer for all that apply):

History of Benign Prostatic Hyperplasia? No OR Yes: (specify date(s) and any treatments received)
_____
History of prostate cancer? No OR Yes: (specify date(s) and treatments) _____
_____
History of hemorrhoids or other colorectal problems? No OR Yes: (specify date(s) and treatments)
_____
History of sexually transmitted diseases: No OR Yes: (specify active infections)_____
History of chronic urinary / bladder infections? No OR Yes: (specify)_____

Goals you want to achieve through therapy (be specific): _____
_____