FMCC Fertility & Midwifery Care Center

A#_____

Male Patient Health History

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

Family Doctor: _____ **Referred By:** _____

Reason for visit: _____ **Date:** _____

Medical History

Do you urinate more than once every 2 hours?	Yes	No	Are you sexually active at this time?	Yes	No
Do you have a sense of "urgency" to urinate?	Yes	No	Are you sexually inaction due to pain?	Yes	No
Do you have symptoms of leaking urine?	Yes	No	Are you sexually inactive for other reasons?	Yes	No
Do you have interstitial cystitis?	Yes	No	Do you have Irritable Bowel Syndrome?	Yes	No
Do you have pain in your bladder?	Yes	No	Do you leak gas or feces?	Yes	No
Do you have pain with urination?	Yes	No	Do you have constipation?	Yes	No
Do you have pain with erection?	Yes	No	Do you have pain with bowel movements?	Yes	No
Do you have pain with ejaculation?	Yes	No	1 fall with injury in the last 6 months	Yes	No
Do you have history of an enlarged prostate?	Yes	No	2 or more falls in the last 12 months	Yes	No
CONSISTENCY OF STOOL			# trips/slips/near falls _____		
___Hard ___Soft ___Liquid ___Pencil Thin					

Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

Circle the words that apply to how you have been feeling lately and/or choose your own words

Abuse	Afraid	Anxious	Overwhelmed	Overworked	"Postpartum blues"
Calm	Content	Depressed	Sad	Stressed	Strong
Energetic	Flabby	Happy	Tired	Unmotivated	Unrest
Lethargic	Lonely	Neglected	Unsafe	Weak	Other_____
Not bonding with babies		Optimistic	Other _____		

Nutrition

Current Weight: _____ lbs

I would like to lose/gain weight? (Circle one)	I have gained/lost more than 10 lbs in the past year. (Circle one)
Are you currently on a specific diet? (Circle below if yes) Low Carb/Keto South Beach Paleo Atkins Weight Watchers Other_____	Would you say your diet is "unhealthy?" (Circle below if yes) High Amounts of Fast Food Low Vegetable Intake High Fat High Carb Other _____

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Fluid Intake

What do you drink every day? (Please Circle)

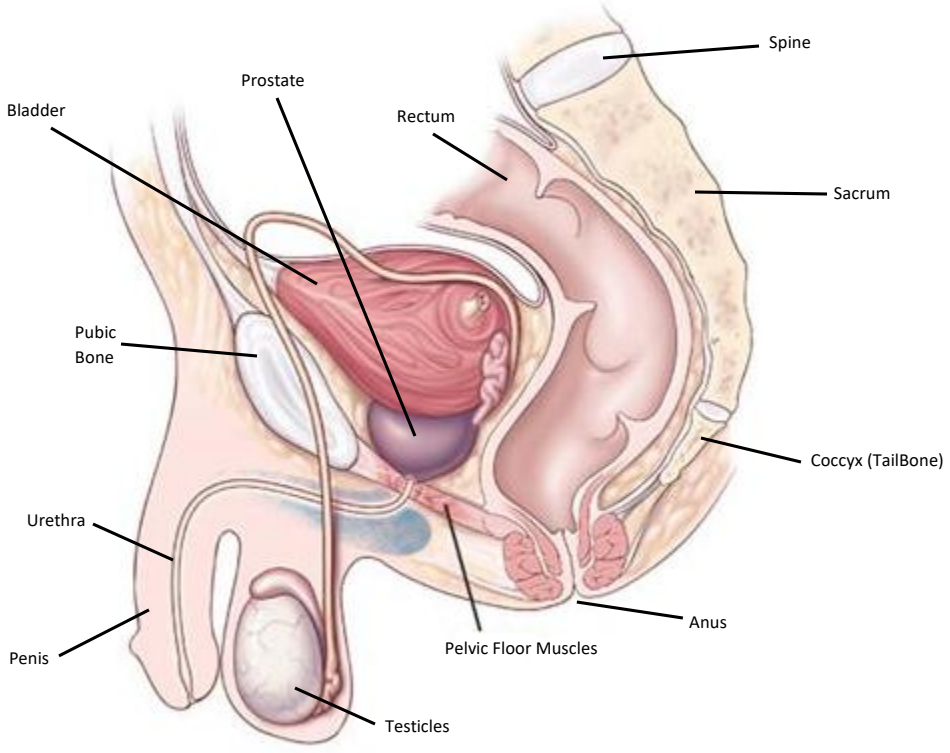
Water Diet Soda Regular Soda Tea Beer Wine

Regular Coffee Decaffeinated Coffee Liquor Milk Juice

Other _____

Tell Us About Your Perineal and Pelvic Pain

Please mark with an "X" where your pain begins and then shade in any other areas of pain.



What started this problem? _____

Circle the words that describe your pain:

Hot Burning Scalding Miserable Intense Unbearable

Searing Sharp Cutting Discomforting Tearing Annoying

Troublesome Other_____

Please circle anything that makes your pain better:

Heating pad Resting in bed Resting in a chair Medication Cream

Abstaining from sexual intercourse Ice Pack Not wearing tight clothes

What treatments (if any) have you had for this problem?

TREATMENT	DID THE TREATMENT HELP?
1)	
2)	

Indicate the level of difficulty you have with the items listed below:

(Write a number in the Score column **ONLY** that describes your level of ability from 0 – 4.

0 = Not difficult at all **1** = Hardly difficult **2** = Slightly Difficult **3** = Medium Difficulty **4** = Extreme Difficulty or **N/A**

	Score	**Date**		**Date**	**Date**	**Date**
Example: Pain with urination	3	Goal	Wks	Progress		
FUNCTIONAL/PERINEAL PROBLEMS						
Physician able to insert finger into the rectum for examination						
Achieve erection (with no pain)						
Achieve ejaculation (with no pain)						
Hypersensitivity to touch in perineal area						
Itching in perineal area						
Burning/pain in rectal area						
Burning/pain in the area of the penis or testicles						
Friction with clothing						
Pain with bowel movement						
Pain with urination						
Pain with full bladder						
MEASURES FOR SITTING						
Sitting 0 – 15 minutes						
Sitting 16 – 60 minutes						
Sitting 1 – 2 hours						
Sitting 2 – 4 hours						
EFFECT OF PROBLEM ON DAILY LIFE						
Affects choice of clothing						
Walking short distances						
Walking long distances						
Exercise in gym						
Ride a bike						
Ability to travel to work						
Ability to travel for longer than 2+ hours						
Interferes with social activity (movies, socializing)						
Interferes with my sex life						
Negatively impacts relationship with my partner						
Negatively impacts interaction with my family & friends						
Feelings of depression, anxiety, embarrassment, frustration or anger *(circle any that apply)*						
Pain impairs my ability to concentrate/function						
Pain impairs my ability to work “normal” work hours						
TOTAL						