

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

## Male Symptom Monitor

Occupation: \_\_\_\_\_ Recreational Activities: \_\_\_\_\_

Presenting problems:

1. \_\_\_\_\_

2. \_\_\_\_\_

When did this start? \_\_\_\_\_

***Please fill out each section that is relevant to your problem***

**Have you had any of the following medical procedures?;**

Appendectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia repair	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vasectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemorrhoid banding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostatectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cystoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urodynamics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bowel resection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gallbladder removal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other			

**Bladder Symptoms:**

Did you have problems with your bladder during childhood?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you have leakage associated with sneezing, coughing, running and/or laughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you have leakage during intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you feel really strong sensations prior to voiding but don't leak?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Does your leakage occur after having a strong urge that feels uncontrollable?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you have pain when your bladder fills?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Does your pain improve when you void?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you have pain when you void?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you have to strain in order to empty your bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you have difficulty starting your urine stream?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you have dribbling after you get up from the toilet?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you stand to void?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you have incomplete emptying when you void and feel like you have to go again soon?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do your bladder problems cause you to leak at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Does your incontinence fluctuate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
Does your incontinence require you to wear pads?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
If you answered yes or sometimes, how often?	
Do you void during the day more than the average person (5-7x/day)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes



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If you answered yes or sometimes, how often?	
Do you need to get up at night to void?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
If you answered yes or sometimes, how many times?	

**Fluid intake in 24 hours:**

# \_\_\_\_\_ cups of water/day                      # \_\_\_\_\_ cups of coffee/day  
# \_\_\_\_\_ cups of tea/day                              # \_\_\_\_\_ cups of other fluids/day

Do you have any food allergies or sensitivities?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Digestion & Bowel Function:**

What is the frequency of your bowel movements?	
Do you feel the urge to move your bowels?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have constipation?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you strain to have a bowel movement?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have loose stools/diarrhea?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have bowel urgency that is difficult to control?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you lose control of your bowels?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have incomplete emptying?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have pain <u>with</u> a bowel movement?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have pain <u>after</u> a bowel movement?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Does it take longer than 5 minutes to have a bowel movement?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you have bloating? (Increased pressure in abdomen)	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	<input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Always
In your opinion, is your fibre intake	<input type="checkbox"/> too low <input type="checkbox"/> adequate <input type="checkbox"/> too high
Do you regularly use	<input type="checkbox"/> laxatives <input type="checkbox"/> stool softeners <input type="checkbox"/> natural products <input type="checkbox"/> enemas

**Have you ever been diagnosed with/think you have:**

Irritable bowel syndrome      When? \_\_\_\_\_ Who? \_\_\_\_\_  
Ulcerative colitis                      When? \_\_\_\_\_ Who? \_\_\_\_\_  
Crohn's Disease                      When? \_\_\_\_\_ Who? \_\_\_\_\_  
Celiac Disease                      When? \_\_\_\_\_ Who? \_\_\_\_\_

**Sexual history:**

Last PSA score: \_\_\_\_\_ When? \_\_\_\_\_ Last digital rectal exam? \_\_\_\_\_  
Does your prostate get painful/irritated?                      o Yes o No



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Has your prostate fluid been expressed and tested?    o Yes o No  
 Do you have painful erections?    o Yes o No  
 Can you achieve a satisfactory erection?    o Yes o No  
 Do you have premature ejaculation?    o Yes o No  
 Do you have pain during intercourse?    o Yes o No    When? \_\_\_\_\_

***Medical History:***

Urinary tract infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?
Antibiotics recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last UTI?
Probiotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cranberry supplementation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No	# _____ packs/day
Chronic cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____ Frequency: _____
Do you get blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies (including latex):	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Low back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mid back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Neck problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been treated for depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What treatment?
Have you ever been treated for anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whar treatment?

***On a scale from 1-10, please circle and rate how much this problem bothers you:***

**1 2 3 4 5 6 7 8 9 10**

***On a scale from 1-10, please circle and rate how motivated you are to correct this problem***

**1 2 3 4 5 6 7 8 9 10**



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### **DASS Questionnaire**

Please read each statement and circle a number, 0, 1, 2, or 3, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

S = \_\_\_\_\_ A = \_\_\_\_\_ D = \_\_\_\_\_

0 = It did not apply to me at all

1 = Applied to me to some degree or some of the time

2 = Applied to me a considerable degree, or a good part of the time

3 = Applied to me very much, or most of the time

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| I find it hard to wind down.....  | S | 0 | 1 | 2 | 3 |
| I was aware of dryness of my mouth.....   | A | 0 | 1 | 2 | 3 |
| I could not seem to experience any feeling at all.....  | D | 0 | 1 | 2 | 3 |
| I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion..... | A | 0 | 1 | 2 | 3 |
| I found it difficult to work up the initiative to do things.....  | D | 0 | 1 | 2 | 3 |
| I tended to over-react to situations.....   | S | 0 | 1 | 2 | 3 |
| I experienced trembling (e.g. hands).....   | A | 0 | 1 | 2 | 3 |
| I felt that I was using a lot of nervous energy.....  | S | 0 | 1 | 2 | 3 |
| I was worried about situations in which I might panic and make a fool of myself....   | A | 0 | 1 | 2 | 3 |
| I felt that I had nothing to look forward to.....   | D | 0 | 1 | 2 | 3 |
| I found myself getting agitated.....  | S | 0 | 1 | 2 | 3 |
| I found it difficult to relax.....  | S | 0 | 1 | 2 | 3 |
| I felt down-hearted and blue.....   | D | 0 | 1 | 2 | 3 |
| I was intolerant of anything that kept me from getting on with what I was doing....   | S | 0 | 1 | 2 | 3 |
| I felt I was close to panic.....  | A | 0 | 1 | 2 | 3 |



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- I was unable to become enthusiastic about anything..... D 0 1 2 3
- I felt I was not much of a person..... D 0 1 2 3
- I felt that I was rather touchy..... S 0 1 2 3
- I was aware of the action of my heart in the absence of physical exertion  
(e.g. sense of heart rate increase, heart missing a beat)..... A 0 1 2 3
- I felt scared without any good reason..... A 0 1 2 3
- I felt that life was meaningless..... D 0 1 2 3

