Saint John's Health Center
PROVIDENCE Health & Services

MENS HEALTH QUESTIONAIRE

The following questions will help us determine what problems you have and what needs to be done prior, during or after your visit. Please complete this at least 3 days before the visit and email or fax it back to the Doctor's office. Please fill in all **six** pages. It is long because it is comprehensive. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

1. **Who referred you to my practice? (Circle one)**
   Patient Family member Physician Name? _____

2. **What is the main reason for today's visit? _____**

3. **Do you have any other concerns? _____**

What are your health goals for the next year? _____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers you see regularly as well as their specialty:

Name	Specialty	Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Saint John's Health Center
PROVIDENCE Health & Services

MENS HEALTH QUESTIONAIRE

Urinary symptoms

1.	Do you need to urinate every 1-2 hours or more?			Y	N
2.	Do you have the urge to go even with an empty bladder?			Y	N
3.	Have you have lost control of urination?			Y	N
4.	Do you have burning with urination?			Y	N
5.	Pain with urination?			Y	N
6.	A weak urinary stream?			Y	N
7.	Do you have to wait a while before you stream starts?			Y	N
8.	Do you empty your bladder completely?			Y	N
9.	How many times at night do you wake up? (circle one)	0-1	2-3	4-5	6+
10.	Do you take any medications for your urination?			Y	N
11.	Have you ever had any kidney stones?			Y	N
12.	Have you ever seen blood in your urine?			Y	N
13.	Have you ever had a urinary tract infection?			Y	N
14.	Do you have any pain in your pelvis?			Y	N

Please complete the following worksheet:

	Not at All	*Less Than One Time in Five*	*Less Than Half the Time*	*About Half the Time*	*More Than Half the Time*	*Almost Always*
1. Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2. Over the past month or so, how often have you had to urinate again less than 2 hours after you finished urinating?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3. Over the past month or so, how often have you found you stopped and started again several times when you urinated?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. Over the past month or so, how often have you found it difficult to postpone urination?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. Over the past month or so, how often have you had a weak urinary stream?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. Over the past month or so, how often have you had to push or strain to begin urination?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

0 ☐ none	1 ☐ one time	2 ☐ two times	3 ☐ three times	4 ☐ four times	5 ☐ five or more times

Total I-PSS Score = Sum of Questions 1–7 = ___

Quality of Life Due to Urinary Symptoms

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

Delighted	Pleased	Mostly Satisfied	Mixed (about Equally Satisfied and Dissatisfied)	Mostly Dissatisfied	Unhappy	Terrible
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

Sexual Health

1. Use the following scale for the next 8 questions:
   1=terrible, 2=poor, 3=average, 4=good, 5=excellent
   a. How would you rate your sex drive? _____

MENS HEALTH QUESTIONAIRE

b. How would you rate your energy level? _____
c. How would you rate your strength/endurance? _____
d. How would you rate your enjoyment of life? _____
e. How would you rate your happiness of life? _____
f. How would you rate your work performance in the past 4 weeks? _____
g. How would you rate your sports ability over the past 4 weeks? _____
h. How strong are your erections? _____
i. How often do you fall asleep after dinner? (circle one)
Never 1-2x's/wk 3-4x's/wk 5-6/week Every night _____
j. How much height have you lost in your adulthood? (circle one)
2'' or more 1.5-1.9 1-1.4 0.5-0.9 none _____
Total: _____

2. Do you have a history of low testosterone? Y N
3. Do you have a history of an undescended testicle? Y N
4. Do you have a history of a testicular mass? Y N
5. Do you have a history of a varicocele? Y N
6. Do you get morning erections regularly? Y N
7. Do you use or have you used any medications for erections? Y N
8. Do you have pre-mature ejaculation? Y N
9. Do you have any penile plaques or deformities? Y N
10. Do you have painful erections? Y N
11. Do you have diminished penile sensation? Y N
12. Have you experienced penile trauma? Y N

Please complete the following worksheet:

Fertility

1. How do you rate your confidence that you could keep an erection?

1	2	3	4	5
Very low	Low	Moderate	High	Very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

1	2	3	4	5
Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

1	2	3	4	5
Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always

1.Are you and your partner trying to have

MENS HEALTH QUESTIONAIRE

children? Y N
(If "no" skip to next section)
2. Have you or your partner had issues with fertility? Y N

Diet and Lifestyle Assesment

Smoking History

1. Do you currently smoke? Y N
(If you have never used any tobacco, skip to Alcohol Use section below)
   a. Approximately how many packs/day do you smoke? _____
2. Have you smoked in the past?
   a. If yes, when did you quit? _____
   b. Approximately how many packs/day did you smoke? _____
3. Are you exposed to 2nd hand smoke? Y N

Alcohol Use

4. Do you drink alcohol? Y N
   a. # of drinks/week: _____ □ Beer □ Wine □ Liquor
   b. How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day? _____

Drug Use

5. Have you **ever** used recreational drugs? Y N
   a. If yes, which ones? _____
   b. Quit which ones? □ All _____
   c. Any used currently? _____

Safety

6. Does your home have a working smoke detector? Y N
7. Do you have guns in your home? Y N
   a. If yes, are they locked up & ammo stored separately? Y N
8. Are you or have you been exposed to toxic chemicals at work/hobbies? Y N
9. Do you use a helmet for recreational activities? (e.g. bike, skateboard, ski) Y N
10. Do you use seatbelts consistently? Y N
11. Have you or any family member ever been hurt/insulted/threatened? Y N

Diet/Exercise

12. Do you follow any specific diet? Vegan Gluten-free Other_____
13. Do you consider yourself in shape? Y N
14. Do you exercise regularly? Y N
   a. If yes, what type(s) and how often? _____
15. Do you have any injuries or pain that limit activity? Y N
16. Do you have any pain or discomfort with any of the following?
   a. Going up and down stairs? Y N
   b. Prolonged standing? Y N
   c. Prolonged sitting? Y N
   d. Prolonged walking? Y N
   e. Reaching overhead? Y N
17. Do you have difficulty with walking or keeping your balance? Y N
18. Have you had any falls in the last 12 months? Y N

If you answered yes to any of the following questions please explain:

Cardiac Health Assessmet

1. Do you have a cardiologist? Y N
   a. If yes please provide their name and number: _____

Saint John's Health Center
PROVIDENCE Health & Services

MENS HEALTH QUESTIONAIRE

2. Have you had an EKG in the last year? Y N
3. When was your cholesterol last checked? _____
4. Do you have the results? Y N
   a. If Yes: Total Cholesterol: _____
   LDL: _____
   HDL: _____
5. Have you ever had a cardiac stress test? Y N
   a. If yes, when? _____
   b. What were the results? □ Normal □ Other: _____
6. Have you had a carotid duplex? Y N
7. Have you had a cardiac calcium scan? Y N

Cancer Screening

Prostate CA:

1. Do you have a family history of prostate cancer? Y N
2. Have you ever had a PSA drawn? (this is a test to screen for prostate cancer) Y N
3. Do you have a personal history for an elevated PSA? Y N
4. Have you ever undergone a prostate biopsy? Y N

Lung CA:

1. Do you have a smoking history of more than 30 pack years? Y N
2. Have you undergone a CT of the chest in the last year? Y N

Colorectal CA:

1. Do you have a personal or family history of colon cancer? Y N
2. Have you ever had a colonoscopy?
   a. If yes, when? _____
   b. Any abnormalities? Y N
3. Any history of inflammatory bowel disease? Y N

Skin CA:

1. Do you have daily sun exposure? Y N
2. Do have a dermatologist? Y N
3. Do you normally wear sun protection? Y N
4. When was your last skin exam? _____

Psychiatric Risk Assessment

Over the last 2 weeks have you had any of the following:

1a. Feeling nervous, anxious, or on edge? (circle one)
No days (0), Several days (1), 7 or more days (2), Nearly everyday (3) _____

1b. Not being able to stop or control worrying? _____
No days (0), Several days (1), 7 or more days (2), Nearly everyday (3)
Total Score: _____

2a. Little interest or pleasure in doing things?
No days (0), Several days (1), 7 or more days (2), Nearly everyday (3) _____

2b. Feeling down, depressed or hopeless? _____
No days (0), Several days (1), 7 or more days (2), Nearly everyday (3)
Total Score: _____

3. In the past year have you had more than 5 drinks in one day? Y N

MENS HEALTH QUESTIONAIRE

MEDICATIONS: Please list (or show us your own printed record) of **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).
□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

Medication Name	Dose (e.g. mg/pill)	How many times per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES or intolerance to medications? □ NONE
(If yes, to what & what reaction?) _____

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.
Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____
Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____
Meningitis _____ Zostavax (shingles) _____ HPV _____

PERSONAL MEDICAL HISTORY
□ **Check box if you have no history of significant medical illnesses.**
Do you currently have or have you had (in the past) any of the following conditions?

Condition	***Now***	***Past***	***Comments***
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Colon			

MENS HEALTH QUESTIONAIRE

Cancer Other Type			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures (broken bones)			
Where?			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			

MENS HEALTH QUESTIONAIRE

Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other (list)			
Other (list)			

SURGICAL & PROCEDURE HISTORY

□ **Check box if you have never had any medical procedures or surgeries.**

Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	***Year***	***Comments***
Abdominal surgery		
Angiogram (heart)		
Angiogram (vascular)		
Appendectomy (appendix removal)		
Back surgery (lumbar)		
Biopsy (location in comments)		
Breast Biopsy		
Circle: Right Left Both		
Breast surgery		

MENS HEALTH QUESTIONAIRE

Circle: Right Left Both		
Cataract surgery		
Colonoscopy		
Coronary Bypass		
Coronary Stent		
C-Section		
Echocardiogram (heart)		
EGD (Stomach Endoscopy)		
Gallbladder Removal		
Heart Surgery (other)		
Hip Surgery		
Circle: Right Left Both		
Knee Surgery		
Neck (Spine) surgery		
Circle: Right Left Both		
Pulmonary Function Test		
Sigmoidoscopy		
Sinus Surgery		
Stress Test (stress echo)		
Stress Test (thallium/perfusion)		
Stress Test (treadmill)		
Tonsillectomy		
Vasectomy		
Other (list)		

FAMILY HISTORY
Adopted? □ No □ Yes. If adopted and you do not know your family history, skip the Family History section.
Indicate which relative has had the following diseases (parents, brothers & sisters are the most important).

MENS HEALTH QUESTIONAIRE

	Mother	*Father*	*Sisters*	*Brothers*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	*Other Blood Relatives*
Alive									
Age currently or at death									
Diseases & Conditions									
No significant history known									
Hypertension – high blood pressure									
Hyperlipidemia – high cholesterol									
Heart Attack, Angina									
Diabetes Type II (adult onset)									
Cancer, Breast									
Cancer, Colon									
Cancer, Prostate									
Osteoporosis									
Depression									
Alcoholism / Drug abuse									
Alzheimers									
Asthma									
Autoimmune Disease									
Bleeding or Clotting Disorder									
Cancer, Lung									
Cancer, Ovarian									
Cancer, Other type									
Colon Polyp									
Diabetes Type I (childhood onset)									

MENS HEALTH QUESTIONAIRE

Emphysema (COPD)									
Genetic Disorder (explain)									
Glaucoma									
Heart Disease (CHF)									
Heart Disease (Other)									
Hepatitis B or C									
Hip Fracture									
Hypothyroidism / Thyroid Disease									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Stroke									
Sudden Cardiac Death									

SOCIOECONOMIC:
Occupation (or prior occupation): _____
Employer: _____
Are you: □ Retired □ Unemployed □ On a leave of absence □ Disabled □ Homemaker □ Other_____
Marital status: □ Single □ Partner □ Married □ Divorced □ Widowed
Spouse/partner's name: _____
Number of children: _____ Ages (if minors): _____ # of grandchildren: _____
Education: □ High school or GED □ Trade school □ College □ Graduate school □ Other _____

MEDICAL FORMS:
Please check any of the following forms you have completed:
□ Advance Directive for Health Care (ADHC)
□ Durable Power of Attorney (DPA) for healthcare decisions
□ Living Will
□ POLST (Physician Orders for Life Sustaining Therapy)
□ Know about these or have the forms but have not completed them
□ Don't know what these are

REVIEW OF SYSTEMS Do you currently have any of the following problems?
Please check all that apply to you. If none apply, please leave blank.

CONSTITUTIONAL □ Weight loss □ Weight gain □ Fever □ Fatigue □ Chills □ Other
EYES □ Double vision □ Spots before eyes □ Vision changes □ Other
ENT MOUTH □ Earaches □ Ringing in ears □ Sinus problems □ Headaches □ Mouth sores
□ Sore throat □ Dental problems □ Rhinorrea □ Nasal bleeding □ Other

MENS HEALTH QUESTIONAIRE

CARDIOVASCULAR □ Chest pain □ Heart palpitations □ Painful breathing □ Swelling □ Other
RESPIRATORY □ Wheezing □ Shortness of breath □ Chronic cough □ Phlegm production □ Hemoptysis □ Other
GASTROINTESTINAL □ Diarrhea □ Abdominal Pain □ Constipation □ Bloody stool □ Cramping □ Nausea/vomiting □ Hematochezia □ Hematemesis □ Other
URINARY □ Blood in urine □ Pain with urination □ Urinary frequency □ Urgency □ Incomplete emptying □ Leak urine with coughing □ Other
MUSCULOSKELETAL □ Bone pain □ Muscle weakness □ Muscle pain □ Change in strength □ Joint pain □ Change in range of motion □ Other
SKIN □ Skin rash □ Lesions □ Other
NEUROLOGICAL □ Dizziness □ Seizures □ Numbness □ Difficulty Walking □ Headache □ Other □ Spine injury □ Back injury/pain □ Radiculopathy
PSYCHIATRIC □ Depression □ Suicidal ideation □ Psychosis □ Anxiety □ Other
ENDOCRINE □ Hot flashes □ Abnormal thirst □ Increase facial/body hair □ Other
HEMATOLOGIC □ Frequent bruising □ Enlarged lymph node □ Bleeding problems □ Lymphedema
□ Other

Thank you for taking the time to complete this form!